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Access to Health Care: States Respond to Growing Crisis

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The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Ron Wyden
Chairman, Subcommittee on Regulation, Business Opportunities, and Energy
Committee on Small Business
House of Representatives

This report, prepared at your request, reviews state initiatives to expand access to health insurance and control rising health care costs. The report describes comprehensive plans to provide universal access to coverage, programs to extend access to specific groups, and efforts to control costs by reforming payment mechanisms.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to interested congressional committees and make copies available to others on request.

This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who may be reached on (202) 512-7119 if you or your staff have any questions. Major contributors to this report are listed in appendix I.

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Executive Summary

Purpose

Providing health care to every American has become one of the most serious problems facing the nation. The number of individuals without—or with inadequate—health insurance is increasing, while the cost of providing care is growing. Chairmen John Dingell and Ron Wyden asked GAO to report on state initiatives to address the problems of access and affordability in the health care system and federal barriers that limit state options to achieve universal access to health care.

Background

State governments have a major stake in financing and providing health care. States are concerned about the growing proportion of their budgets devoted to health—they already spend an average of 20 percent of their total budgets on health-related programs. Yet in some states, almost one-quarter of the population is uninsured.

In responding to the health care crisis, states are constrained by their budgetary problems. In addition, state reforms must comply with federal laws and regulations. The Employee Retirement Income Security Act of 1974 (ERISA) preempts state authority to regulate self-insured employer health plans. While ERISA primarily reacted to problems dealing with the solvency of employer-sponsored pension plans, its impact on employer-provided health benefits has grown as more firms have self-insured for health benefits. Over half of U. S. workers are employed in firms that self-insure, and states cannot require such employers to provide a specific health plan or pay state-imposed premium taxes. In addition, if a state wants to integrate the Medicaid program with a state plan, it needs federal permission to do so.

Results in Brief

States have taken a leadership role in devising strategies to expand access to health insurance and contain the growth of health costs. One hurdle that is difficult for states to overcome, however, is the restrictions imposed by ERISA's preemption clause. This clause effectively prevents states from exercising control over all employer-provided insurance. Hawaii, in part because its law requiring employers to provide health insurance took effect before ERISA was enacted, is the only state with an exemption. Even its exemption, however, has frozen the Hawaiian law in its original form, preventing state officials from making the improvements they would like to make.

Other states that have tried to move toward coverage of all their citizens have had to work within ERISA's constraints. One strategy, used by

Massachusetts and Oregon, has been to create "play-or-pay" systems that rely on the state's power to tax. Employers are required to pay a tax to help finance state-brokered insurance; if they provide health insurance to employees, they generally receive a credit for the amount they spend on coverage. These laws, however, are expected to face legal challenges based on ERISA, and the outcome is uncertain.

Some state initiatives have been more narrowly focused, creating programs to assist specific groups, such as low-income children and adults. These have successfully extended coverage to some residents, but state budgetary constraints have limited the programs to serving a small fraction of the uninsured population.

State efforts to help the medically uninsurable and small business employees gain access to coverage through the private health insurance market have also achieved modest results. In addition, while most states have concentrated on expanding access, a few have implemented payment reforms to control medical inflation and reduce administrative costs. Maryland, for example, has lowered cost growth through its hospital rate-regulation system.

GAO's Analysis

Hawaii Approaches Universal Access With Help of ERISA Exemption

In some states, debate no longer centers on whether to set a goal of ensuring universal access to health care coverage, but on how to achieve it. Hawaii was the first state to try to extend coverage to all its residents, and its uninsured rate is the lowest of all the states. The principal tool that has allowed Hawaii to approach universal access is its 1974 law requiring employers to provide health insurance for full-time workers. Hawaii is able to enforce this requirement because its 1974 law is statutorily exempt from the ERISA preemption provision. State requirements that virtually all employers provide insurance and that insurers cover all employees reduce uncompensated care and cost shifting. Most residents not covered by employers or Medicaid are eligible for a state-subsidized insurance program with less extensive benefits. Hawaii officials would like to refine their system, but the ERISA exemption precludes the state from modifying its existing employer-mandate law.

Massachusetts Faces Delays and Obstacles

States adopting universal access plans more recently did not have Hawaii's option of requiring employer-provided insurance and had to devise other approaches. When Massachusetts enacted its package of reforms in 1988, it designed a play-or-pay provision that requires employers to pay a tax to a state-brokered health insurance fund. Employers that provide health insurance to employees may generally deduct their costs for providing the insurance from the required contribution. Although the play-or-pay system was specifically designed to be compatible with the requirements of ERISA, state officials are not sure whether it would withstand a legal challenge. Implementation of the play-or-pay requirement has been delayed until 1995. Programs targeted to specific uninsured groups—such as unemployed workers and disabled people—have been implemented and made some progress in expanding access to insurance, but tight budgets limit their effectiveness.

Oregon's Comprehensive Approach Requires Federal Waivers

Oregon, too, when enacting a comprehensive package of initiatives in 1989, chose a play-or-pay mechanism in the hope of avoiding an ERISA problem. Its requirement will go into effect in 1995, unless private market reforms are successful in reducing the uninsured population. One of the state initiatives is a Medicaid expansion that extends Medicaid benefits to all residents with incomes below the poverty level, including those who would not normally qualify for federal funds. Certain health services in the current benefits package would no longer be covered. The Medicaid expansion requires a number of waivers from the federal government, and implementation of the play-or-pay requirement cannot proceed unless the state obtains the waivers needed to carry out the Medicaid plan. A decision on the waiver request is expected in June 1992.

New Reform Efforts in Minnesota, Florida, and Vermont

Proposals to achieve universal access continue to be developed in the states. Recently, Minnesota, Florida, and Vermont enacted comprehensive reform packages. Minnesota's initiative includes a provider tax to finance subsidized health insurance for low-income uninsured residents and measures to contain costs. Minnesota and Florida may seek ERISA exemptions to give them more flexibility.

Programs for Low-Income Populations Expand Access Incrementally

Instead of adopting comprehensive plans, some states have opted for programs targeted to specific uninsured groups, such as children. One in five American children lives in poverty, and one-third of poor children lack health insurance. Several states have created programs to assist these

children. Access for low-income children is expanded through state-subsidized private health insurance, such as Minnesota's Children's Health Plan, or expanded Medicaid eligibility, such as Vermont's Dr. Dynasaur program. Both approaches successfully expanded access to some uninsured children, but there remain many uninsured children in both states who do not qualify for assistance.

Low-income adults, many of whom fall into the category of the working poor, are another population states have targeted with insurance and Medicaid expansion initiatives. Washington's Basic Health Plan (BHP) provides subsidized health insurance, and the Maine Health Program expands Medicaid eligibility. Budget constraints limit the extent to which these programs reach the target population: BHP enrolls fewer than 20,000 of the estimated 450,000 eligible, and Maine's program has never covered more than 11,400 of its 113,000 uninsured.

States Try to Expand Access to Private Insurance

Most states have also adopted measures to make it easier for people with high-cost health conditions and small business owners and employees to obtain affordable health insurance in the private market. Almost half the states have created high-risk pools to make insurance available to the medically uninsurable—people who cannot obtain conventional insurance because of their medical conditions—and to spread the risk of covering them among all insurers in the state. The funding base for the pools is limited because, as a result of ERISA constraints, the insurance assessments that supplement individual premiums do not apply to self-insured companies.

To address problems in the small business insurance market, states have adopted a broad range of initiatives, including subsidies and regulatory reforms, that attempt to make insurance more affordable and accessible. Thus far, most of these efforts have had only a modest effect on the number of small firms newly offering health insurance to their employees.[1]

Payment Reform Helps Control Costs

While most states have focused their attention on expanding access to coverage, some have made efforts to control increasing costs. Through changes in methods for reimbursing providers, these states attempt to limit the health care system's cost growth and administrative burden. Since 1972, Maryland has operated a hospital rate-setting system that

[1]For a more detailed discussion of state efforts to modify the health insurance market for small businesses, see Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 1992).

provides for nearly uniform payments by all insurers. During this period, Maryland hospital costs per admission fell from 25 percent above the national average to 10 percent below.

In an attempt to reduce administrative costs, New York State is now implementing a system to coordinate health care billing and payment procedures. The Single Payer Demonstration Project is expected to reduce claims-processing costs for participating hospitals.

Matters for Congressional Consideration

States are hampered by the ERISA preemption provision, which makes it difficult to design and implement innovative health care reforms. If the Congress wants to give states more flexibility to develop comprehensive reforms, it should consider whether to amend ERISA so that the Department of Labor can give states a limited waiver from ERISA's preemption clause in order to develop innovative approaches to employer-based health insurance. The Congress could define minimum standards—governing such factors as benefits packages, extent of coverage, and terms under which the waiver might be revoked—that a state must meet to receive and maintain such a waiver.

Agency Comments

As requested, GAO did not obtain written agency comments on this report. GAO discussed the report with Department of Labor officials, who did not agree with our suggestion that the Congress consider amending ERISA to give states greater flexibility in developing comprehensive health care reforms. They believe that it is important (1) to maintain a voluntary approach to employee benefits and (2) to preserve the ability of employee benefit plans to serve employees in many jurisdictions without becoming subject to differing state laws. Because the comprehensive reform efforts of states are a response to perceived shortcomings in the voluntary system, GAO continues to believe that the Congress should consider giving states more flexibility.

Contents

Abbreviations

BHP	Basic Health Plan
CPS	Current Population Survey
DMS	department of medical security
ERISA	Employee Retirement Income Security Act of 1974
HMSA	Hawaii Medical Services Association
HCFA	Health Care Financing Administration
HMO	health maintenance organization
HSP	Health Security Plan
MHP	Maine Health Program
MCHA	Minnesota Comprehensive Health Association
NASBO	National Association of State Budget Officers
PPO	preferred provider organization
SHIP	State Health Insurance Program
WIC	Special Supplemental Food Program for Women, Infants, and Children

Introduction

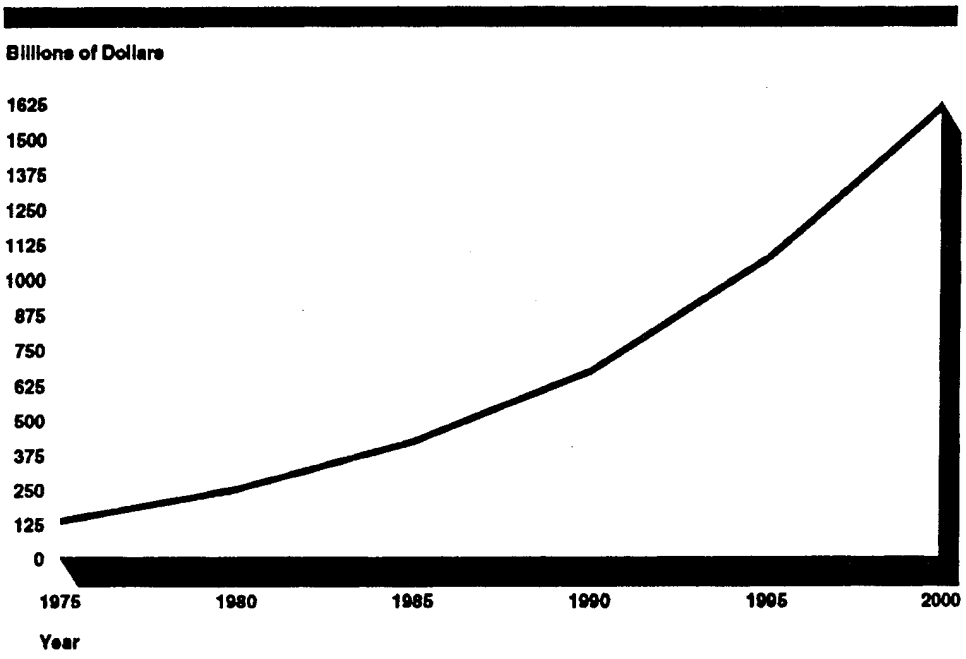
Demand for reform of the United States health care system has been intensifying at both the state and national levels. Each year, the United States spends an increasing share of its resources to provide health care, while it remains one of the few industrialized nations that does not guarantee its citizens universal access to health insurance coverage. Growing health care costs and inadequate access to health care for many have led to a variety of proposals. These range from narrowly focused plans that address the problems of a select group, such as children or the small-group market, to comprehensive reform that addresses the problems of the entire health care market and attempts to ensure health insurance coverage for everyone.

Several states have developed and implemented programs that attempt to expand access or to contain health care costs. More states are currently debating a variety of similar proposals. In light of this activity, Chairmen John Dingell and Ron Wyden requested that we examine some of these state initiatives to assess the lessons they offer for health care reform.

The resources devoted to providing health care in the United States have increased steadily over the past several years, yet at the same time, the number of people without adequate health insurance has increased. In 1991, the United States spent over $700 billion—or 13 percent of its gross national product—to provide health care services, while, by 1990, the number of uninsured people under the age of 65 had increased to over 33 million (see figs. 1.1 and 1.2).

These problems of high health care costs and lack of insurance affect some groups more than others. Children, people with low incomes, and people with high-cost medical conditions are among the groups likely to be uninsured. As health care costs increase, it appears that these groups will have even greater difficulty obtaining health insurance coverage.

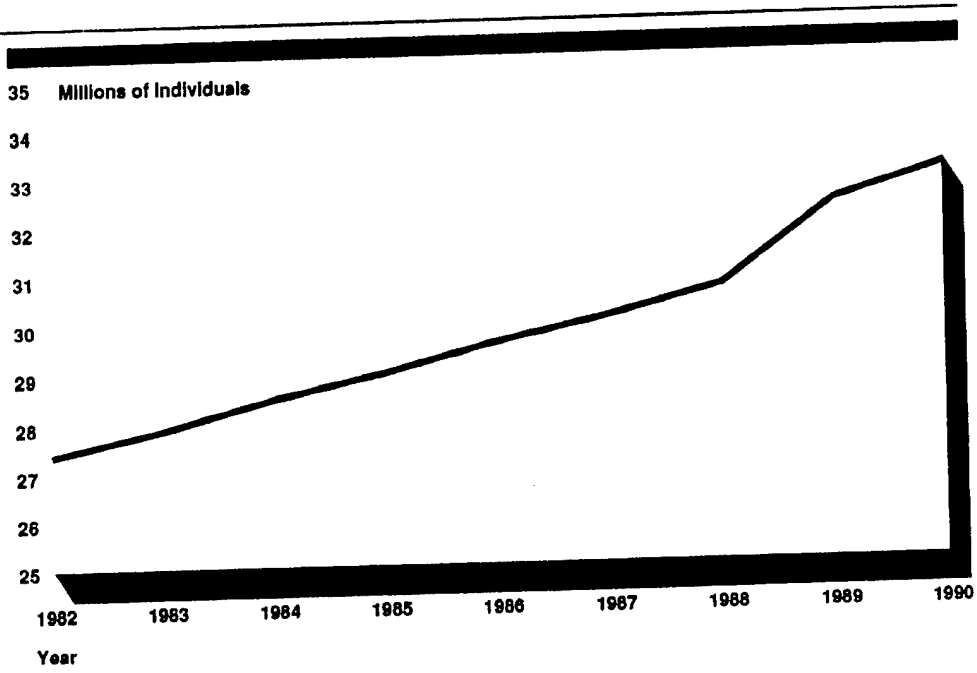
Figure 1.1: National Health Expenditures



Note: Values after 1990 are estimates.

Source: Health Care Financing Administration, Office of the Actuary (1991).

Figure 1.2: Number of Uninsured (1982-90)



Note: The years 1982 through 1987 are estimates.

Source: Health Care Financing Administration, Office of the Actuary.

The Congress Considers Array of Reform Proposals

Currently, the Congress is considering many health care reform bills. Proposals range from insurance market reforms—which modify the current system to make insurance more accessible to employees of small businesses—to single-payer, universal-access systems—which would guarantee health insurance to all Americans through substantial government involvement and financing.

The small business reform bills attempt to address some of the problems in the health insurance market—especially in the small group market—while leaving the rest of the health care system unchanged. These bills would establish rating and underwriting standards aimed at ensuring the availability of health insurance at a reasonable cost to the employees of small businesses, who constitute about half of uninsured workers.

Other proposed legislation would rely on employer-provided insurance and expanded Medicare-like coverage to reach all citizens. These bills generally involve a "play-or-pay" mechanism, which requires employers to

provide health insurance to their employees or pay a tax that goes to a government-sponsored health insurance fund to insure those not covered by employer plans. The government plan, which would provide coverage similar to Medicare, would also insure the unemployed. These bills build on the work of the Pepper Commission,[1] in that they would establish a standard minimum level of insurance benefits, as well as national expenditure limits and quality standards.

Moving beyond employer-provided insurance, some members of the Congress have introduced bills to establish a national health insurance system that uses a single payer. These bills would create a tax-based health insurance system that would guarantee access to health coverage for the entire population. This system is generally modeled on the Canadian health care system.

States Respond to the Problems of High Costs and Lack of Insurance

Because the federal government has yet to take legislative action, the states have taken the initiative and begun to implement their own reforms. In fact, during the 1991 legislative sessions, state legislators in every state introduced some form of health reform plan. As at the national level, the types of reforms vary, ranging from relatively simple insurance reform proposals to expansions for special populations to state-sponsored, guaranteed-access proposals.

Many of these proposals not only attempt to expand access to the uninsured or underinsured, but they also use mechanisms to reduce health care costs. These mechanisms involve the managing of care,[2] reducing administrative costs of the health care system, or both. In many cases, states implementing these cost-reducing strategies hope that the savings achieved will assist the states as they attempt to expand access.

State governments feel pressure to establish reforms because they already have a major stake in financing and providing health care. States are a major purchaser of health care services in this country. Over 13 percent of the average state budget is used to fund Medicaid, which, in 1990, grew by 18 percent; an average 20 percent of a state's budget goes to fund health care programs.

[1] A Call for Action, U.S. Bipartisan Commission on Comprehensive Health Care (Washington, D.C.: Sept. 1990).

[2] States are turning to a variety of approaches to managed care, including health maintenance organizations and preferred provider organizations.

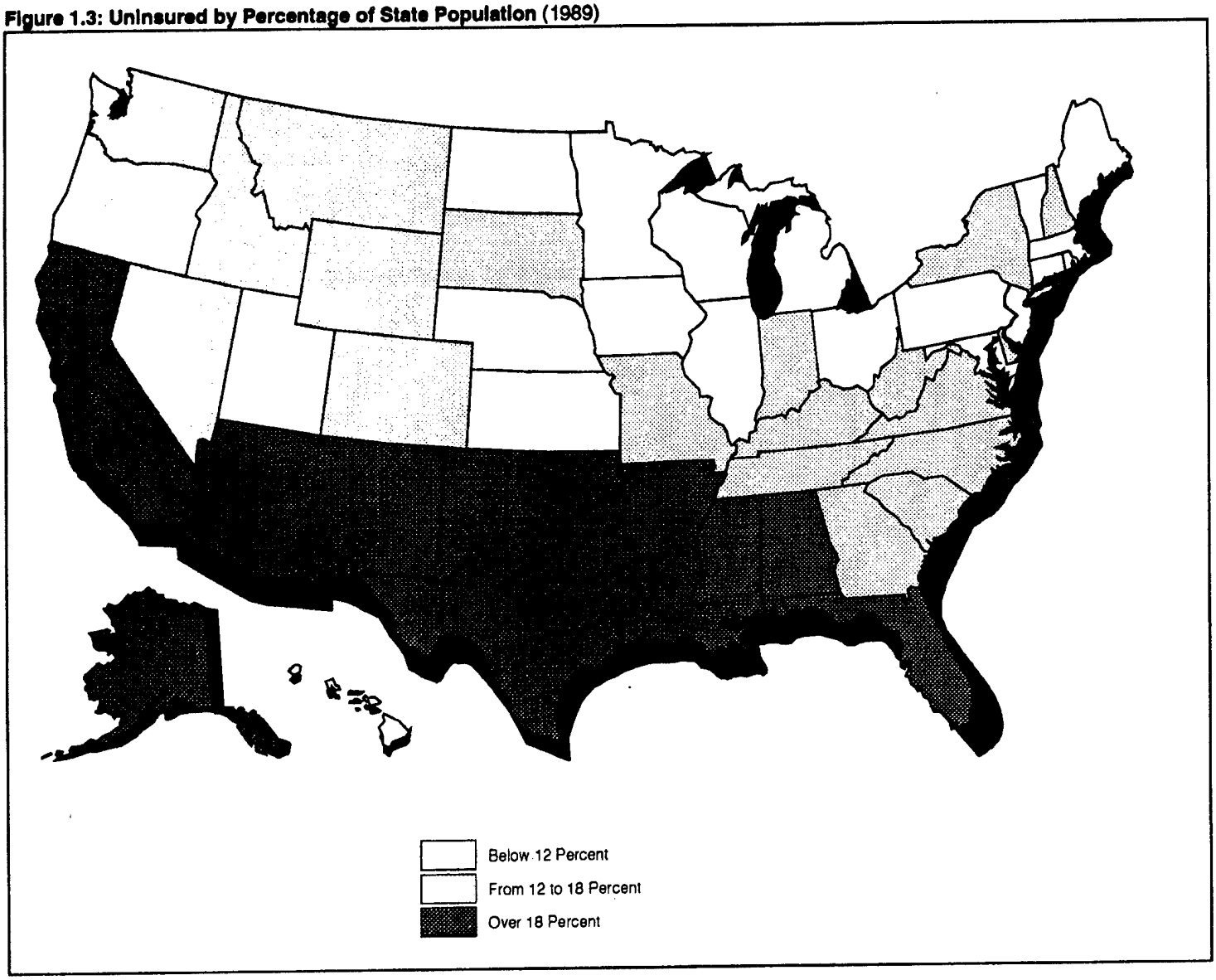
States also fund and administer public health programs, such as immunization and other communicable disease prevention and control activities. They finance health insurance for their employees and provide funds to pay hospitals for indigent care. In addition, they regulate physicians, hospitals, and other health care providers, as well as health insurance companies. With this significant stake in the health care system, many states are developing plans that they hope will reduce cost problems and provide necessary access to care.

States Develop Diverse Plans Responding to Their Individual Needs

Although all states face the same overall access and affordability problems, factors that influence each state's range of possible responses may differ. In an earlier report,[3] we found that some states have more uninsured residents than others (see fig. 1.3). A state may need a markedly different approach to insure more than 25 percent of its population than to extend coverage to less than 10 percent. For example, with relatively few uninsured residents, a state like Hawaii may be able to expand access using one small new program. On the other hand, a state with a higher uninsured rate may need a larger comprehensive reform plan or a combination of several programs to increase coverage.

[3]Health Insurance Coverage: A Profile of the Uninsured in Selected States (GAO/HRD-91-31FS, Feb. 1991).

Figure 1.3: Uninsured by Percentage of State Population (1989)



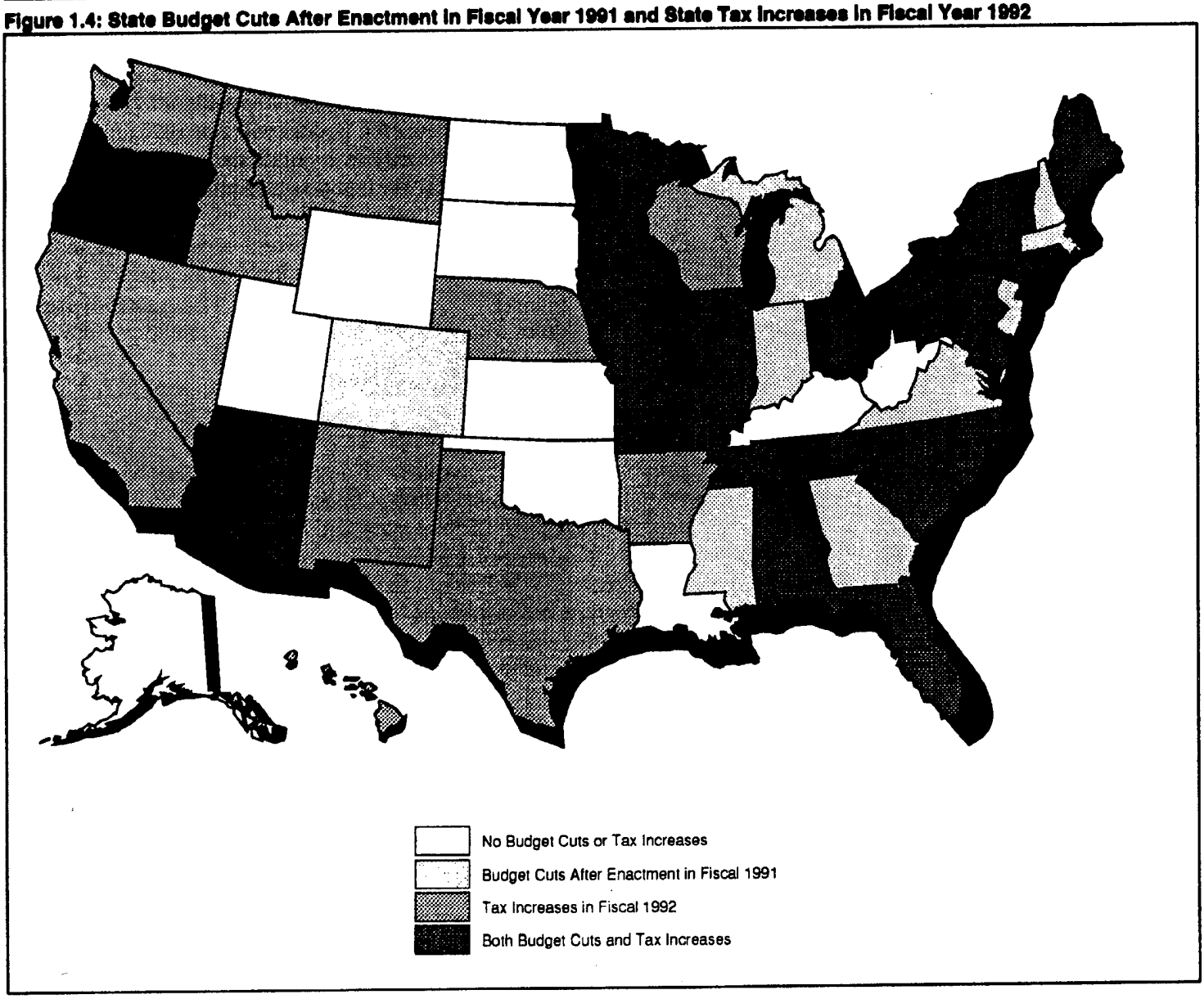
Source: Current Population Survey, Bureau of the Census (March 1990).

Many states also face significant budget problems that limit their ability to initiate health reforms. The condition of the states' fiscal situation has weakened as the national economy has weakened. According to the

National Association of State Budget Officers (NASBO), the states' weakening fiscal situation caused 26 states to raise more than $10 billion in new revenues in fiscal year 1991 in an effort to maintain current programs; furthermore, for fiscal year 1992, the states raised taxes by more than $15 billion. NASBO also reported that the weak economy "forced 29 states to reduce their enacted fiscal year 1991 budgets by more than $7.5 billion to remain in balance."[4] The states that raised taxes, reduced expenditures, or both are shown in figure 1.4. The tightening fiscal constraints faced by the states make it more difficult for them to implement new programs that generate budget costs.

[4]Fiscal Survey of the States, National Association of State Budget Officers, National Governors' Association (Washington, D.C.: Oct. 1991), p. ix.

Figure 1.4: State Budget Cuts After Enactment in Fiscal Year 1991 and State Tax Increases in Fiscal Year 1992



Source: Fiscal Survey of the States, October 1991, National Governors' Association and National Association of State Budget Officers (Washington, D.C.: 1991).

Federal Barriers Limit State Actions

Any state faces federal barriers if it wishes to change its health care system by requiring an employer to provide a defined health insurance package to its employees or by integrating the federal Medicare or Medicaid programs with state programs. The most significant barriers include the Employee Retirement Income Security Act of 1974 (ERISA)—which preempts state authority to regulate certain self-insured employer health plans—and federal Medicaid and Medicare regulations.

When enacted in 1974, ERISA was designed to correct serious problems regarding the solvency of employer-funded pension funds. The act was extended to cover all employee welfare benefit plans, which include health and other employee benefits as well as pensions. ERISA regulates employee benefit plans, including plans providing health benefits, and preempts their regulation by states. ERISA also confirmed the states' authority to regulate insurance companies.

ERISA's preemption provision[5] enables employee benefit plans to serve employees in many jurisdictions without becoming subject to conflicting and inconsistent laws of the various state and local governments. However, it has also produced a divided system for regulating health benefits in each state: the federal government has authority to regulate employee health plans but not health policies sold by insurance companies, and states can regulate health insurance companies and their policies but not employee plans, including health benefits provided by employers who self-insure.

ERISA imposes few requirements on employee health plans, primarily fiduciary and reporting responsibilities and continuation benefits. Health benefits purchased by employers from insurance companies must comply with ERISA, and this insurance policy, in order to be sold by the insurance company, must comply with the state insurance laws.

In 1974, when ERISA was enacted, relatively few firms self-insured for health benefits and ERISA had little effect on health benefit plans. Currently, over half of U.S. workers are employed by firms that self-insure. Thus, ERISA exerts a more significant impact on health benefit plans today than it did when it was enacted. Under ERISA, states cannot require self-insured companies to include mandated benefits in their plans, pay state-imposed premium taxes, or meet state requirements for financial reserves, all of which they require of insurance companies doing business

[5]29 U.S.C. section 1144 (1988).

in their states. Nor can states require all employers to provide a particular health plan without violating the ERISA preemption provision.

Only Hawaii has a limited exemption from the ERISA preemption provisions.[6] When the Congress enacted the legislation, it clearly stated that it was not to be a precedent for granting exemptions to other states.[7]

Maintaining federal Medicare and Medicaid dollars also becomes an important concern when states begin considering more comprehensive reforms. States receive Medicaid funds only if they meet all the relevant federal requirements, and states cannot modify Medicare's reimbursement system without federal approval. If a state's reform plan does not comply with existing Medicare and Medicaid regulations, it must obtain the necessary waivers from the Health Care Financing Administration (HCFA). Obtaining a waiver can be difficult and time-consuming. If a state does not obtain a waiver, it could lose federal matching funds for its Medicaid program or the ability to integrate Medicare into its comprehensive program.

HCFA now has the authority to grant Medicare and Medicaid waivers and, in the case of Medicaid, does so regularly. State Medicaid programs are often granted waivers that allow them to put Medicaid beneficiaries into managed care plans or to develop demonstration projects. Generally, states apply for Medicare waivers to allow them to reform their methods for paying health care providers—such as establishing an all-payer system.[8]

States consider the waiver process difficult for several reasons. First, they must continue to meet, and show that they will continue to meet, all federal regulations not being waived. Second, if HCFA grants a waiver, it is still within the power of the Congress to rescind it. Third, all demonstration waivers have a limited duration. After the demonstration period ends, the program must end, or Congress must change the Medicare or Medicaid statutes to allow a state to continue operating its system.

[6]29 U.S.C. section 1144(b)(5) (1988).

[7]P.L. 97-473.

[8]All-payer systems subject all payers of hospital services to uniform rates. (For an example of an all-payer system, see chap. 5.)

Legislation designed to make it easier for states to be laboratories of health care reform was introduced in the Congress in late 1991.[9] Under this legislation, states that receive federal demonstration grants could obtain a limited exemption from ERISA allowing them to include self-insured employers in their health insurance reform efforts. These states would also have more flexible use of Medicaid, Medicare, and other federal health funds.

Objectives, Scope, and Methodology

At the request of Congressman John D. Dingell, Chairman, House Committee on Energy and Commerce, and Congressman Ron Wyden, Chairman, Subcommittee on Regulation, Business Opportunities, and Energy, Committee on Small Business, we examined a range of state initiatives for health care reform. Specifically, we sought to answer the following questions:

- What are the states doing to address the problems of access and affordability in the health care system?
- What federal barriers exist limiting state options to achieve universal access to health care?

For our review, we studied plans across the country. The reforms we examined either provided a good example of an approach being tried by several states or were the only plans of this type currently operating. The data we evaluated generally were provided directly by state officials administering the plan or came from relevant literature examining those reforms.

We carried out our objectives by the following means:

- We conducted an extensive literature review of a wide range of state reforms to improve the health care system.
- We identified states that illustrate the various approaches to reform. When a program was implemented by several states, we reviewed the one that served the most people or had been in operation the longest time.
- We visited and collected information from state officials that operated or developed the reform plans we studied. We reviewed programs in 17 states: Colorado, Connecticut, Florida, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, New York, Ohio, Oklahoma, Oregon, Vermont, Virginia, and Washington. Our descriptions

[9] S.1972.

of state programs and initiatives were reviewed for accuracy by knowledgeable state officials.

We discussed our report with the Department of Labor and incorporated their comments where appropriate.

We carried out our work from January 1991 through April 1992 in accordance with generally accepted government auditing standards.

States Strive to Achieve Universal Access to Health Care Coverage

There is a growing movement in the states to create programs to provide all state residents with access to health care coverage. In some states the debate has shifted from deciding whether access for all is an attainable and desirable goal to determining the most effective way to achieve it.

In designing systems to achieve universal access, states must take into account internal political and fiscal considerations, as well as federal laws and regulations. To implement a universal access plan based on employer-provided health insurance, for example, a state would need federal legislation to amend ERISA to enable it to have complete jurisdiction over health insurance provided in the state.

States that have thus far enacted plans to attain universal access have opted for a blend of public and private funding mechanisms to provide access. Some states are considering tax-based health insurance systems administered by the government, but the states with initiatives in place continue to use employment-based health insurance as a starting point. They supplement this with public programs to cover those without private insurance.

Hawaii Approaches Universal Access With Employer-Provided Insurance and Public Programs

Hawaii has moved closer to universal access than any other state through its combination of employment-based coverage, Medicaid, and a state-subsidized insurance program for the "gap group"—those not qualified for either employer-provided or Medicaid coverage. The foundation of Hawaii's approach is its requirement that nearly all employers provide health insurance to their employees. Hawaii is unique in its ability to mandate employer-provided insurance; it can do so because the Congress passed legislation exempting Hawaii from certain ERISA provisions.

State officials would like to make improvements to Hawaii's system, but need federal legislation to allow them to modify the requirements for employer-provided insurance or to implement more comprehensive reform. Hawaii's ERISA exemption is limited to the Prepaid Health Care Act as it was passed in 1974; the state cannot amend the act unless specific legislation is passed by the Congress.

Employer-Mandated Insurance Is Foundation of Hawaii's Universal Access System

Hawaii's 1974 Prepaid Health Care Act requires every employer to provide health insurance to its workers, and employees must elect the insurance unless they have comparable coverage from another source. The law does not cover several categories of employees, including part-time workers (those working less than 20 hours per week), government employees, and low-wage earners.[1] Employers and employees share financing of premiums for employee coverage, with the employee contribution limited to the lesser of half the premium cost or 1.5 percent of the employee's gross wages. In 1990, a worker earning the average annual wage of $23,192 would have paid at most $29.00 per month, about one-third the premium cost for individual coverage.

The law outlines two broad categories of benefits plans that employers may provide. The first is an extensive package of medical, hospital, and laboratory services that meets minimum standards specified in the Prepaid Health Care Act.[2] Employers offering such a plan are not required to contribute to the cost of coverage for dependents. Employers have a second option of providing a state-approved benefits package more limited than one of the standard plans,[3] but employers must then pay half the cost of dependent coverage.

The Hawaii government does not collect data on the number of people with employment-based health insurance. Using information from major insurers, however, the state Department of Health estimated that, in 1990, about 88 percent of Hawaii's under-65 population was covered by employment-based insurance. Two insurers cover most Hawaiians with employment-based insurance. The Hawaii Medical Services Association (HMSA), the local Blue Cross/Blue Shield affiliate, provides fee-for-service plans to about 61 percent of the state's insured population; the Kaiser Foundation Health Plan (Kaiser), a staff-model health maintenance organization (HMO), provides care for another 18 percent.

[1]Employers are not required to provide coverage for workers whose monthly earnings are less than 86.67 times the hourly minimum wage, that is, less than $334 per month in 1991. Other excluded categories are newly hired employees (employed less than 4 consecutive weeks), seasonal agricultural workers, insurance and real estate salespeople working on commission, individual proprietorship members in small family-run businesses, and beneficiaries of government assistance programs.

[2]This benefits package is defined as being equivalent to the most prevalent plan provided by the major fee-for-service insurance provider in the state or that provided by the major health maintenance organization.

[3]These plans must still provide basic hospital, medical, surgical, and other benefits, but are likely to require higher copayments or deductibles or have preexisting-condition exclusions for a limited period.

Medicaid Insures Low-Income Residents

In 1990, another 7 percent of Hawaii's residents, about 73,000 people, were insured through Medicaid. Hawaii has a more expansive Medicaid program than most states. It generally accepts people with incomes up to 62.5 percent of the federal poverty level, compared with the average state limit of 45.3 percent.[4] In addition, Hawaii ranks third among the states for the greatest number of Medicaid service options; the federal options it has implemented include programs for pregnant women and infants (to 185 percent of poverty) and the elderly and disabled (to 100 percent of poverty). Medicaid beneficiaries receive a comprehensive benefits package that covers medically necessary, and some preventive, care.

State Health Insurance Program for the Gap Group

In 1989, the Hawaii government estimated that about 5 percent of its population remained uninsured,[5] neither covered through employer-provided insurance nor eligible for Medicaid. The state estimated that of the 50,000 people it counted in this gap group, 30,000 to 35,000 did not have the resources to finance their health care needs. In response to this problem, the Hawaii legislature created the State Health Insurance Program (SHIP), to provide state-subsidized private health insurance for the low-income uninsured. The state legislature appropriated $4 million for initial costs and about $10 million annually for operating costs for fiscal years 1991-92 and 1992-93. SHIP began accepting applications in April 1990 and, as of December 1991, was insuring about 14,600 people, about 30 percent of the state's 1989 estimate of the uninsured population.

The target population for SHIP was thought to consist of the unemployed, the self-employed, part-time and seasonal workers, children and wives of low-income workers, elderly women ineligible for Medicare, immigrants, and students. To be eligible for SHIP, residents cannot (1) have incomes exceeding 300 percent of the federal poverty level or (2) qualify for other government-provided insurance or for coverage under the Prepaid Health Care Act.

The state purchases health insurance for SHIP enrollees from HMSA and Kaiser. Members with incomes between 100 and 300 percent of poverty pay a sliding-scale share of the monthly premium; the state pays the entire

[4]This is the income level for an AFDC family of three. Hawaii's poverty level is $12,810; for all other states, except Alaska, it is $11,140.

[5]State efforts to quantify the number of uninsured produced estimates ranging from 3 to 7 percent. According to Current Population Survey data, about 8.1 percent of Hawaii's population under the age of 65 was uninsured in 1989.

premium for those whose income is under 100 percent of poverty. SHIP members pay a $5 copayment for doctor visits, except for preventive care.

SHIP's benefits package is quite different from Hawaii's employer-provided plans and Medicaid program. Benefits are heavily weighted toward preventive and primary care, with full coverage for prenatal, well-baby, and well-child physician visits, as well as coverage for health appraisals. For other physician care, there is a 12-visit limit, and hospital coverage is limited to 5 days.[6]

Hawaii Closest to Achieving Universal Access, but Benefits Vary

Hawaii has made the greatest progress toward the goal of universal access to health care coverage. Precise measurements of the state's uninsured population at specific times are lacking, but all estimates indicate that Hawaii has succeeded in reducing its uninsured rate and that it currently has the lowest uninsured rate in the nation. Based on Current Population Survey (CPS) data, Hawaii's estimated uninsured rate for 1989 is 8.1 percent,[7] the lowest of all the states. (The CPS nationwide uninsured figure for 1989 is 15.3 percent.)

Since 1989, Medicaid expansions and SHIP have further diminished the percentage of uninsured in Hawaii, but state officials estimate that about 2 percent of Hawaii's population remains uninsured. Those most likely to lack insurance, according to health officials, include homeless people, recent immigrants, runaway adolescents, and people who choose not to purchase health insurance even though they can afford it. Residents without coverage may obtain care from Hawaii's network of community clinics and public hospitals. The state has made vigorous outreach efforts to identify and enroll those eligible for SHIP, and, by the end of 1991, state officials claimed they had enrolled about half of the target population.

Hawaii's mandate for employer-provided insurance has made a substantial contribution to reducing the state's uninsured population. Preliminary results of a recent survey indicate that Hawaiians have easier access to health care services than the U.S. population as a whole.[8] There are, however, limitations to the scope of the Prepaid Health Care Act. Unless

[6]These are the benefits the state purchases from the insurers, but SHIP subscribers who are enrolled in Kaiser's HMO have more comprehensive coverage because Kaiser did not wish to distinguish between its SHIP population and the rest of its membership.

[7]The state estimated, in 1989, that its uninsured rate was 5 percent, based on the entire population; the CPS estimate is based on the population under the age of 65.

[8]The Henry J. Kaiser Family Foundation, Menlo Park, California (forthcoming).

an employer chooses to provide a more restricted plan, there is no requirement for dependent coverage. Neither the Hawaii government nor insurers could pinpoint the number of dependents who remain uninsured or must obtain their coverage through SHIP.

The specific benefits for which residents are insured vary according to the individual's source of coverage. The SHIP plan covers only 5 days of hospitalization, no prescription drugs, and only limited mental health services. While the standard fee-for-service plan under the employer mandate provides far more generous coverage in general, it has less preventive coverage than SHIP. Medicaid provides a comprehensive benefits package, but beneficiaries may have difficulty finding providers willing to serve them, particularly if they live in rural areas of the state.[9]

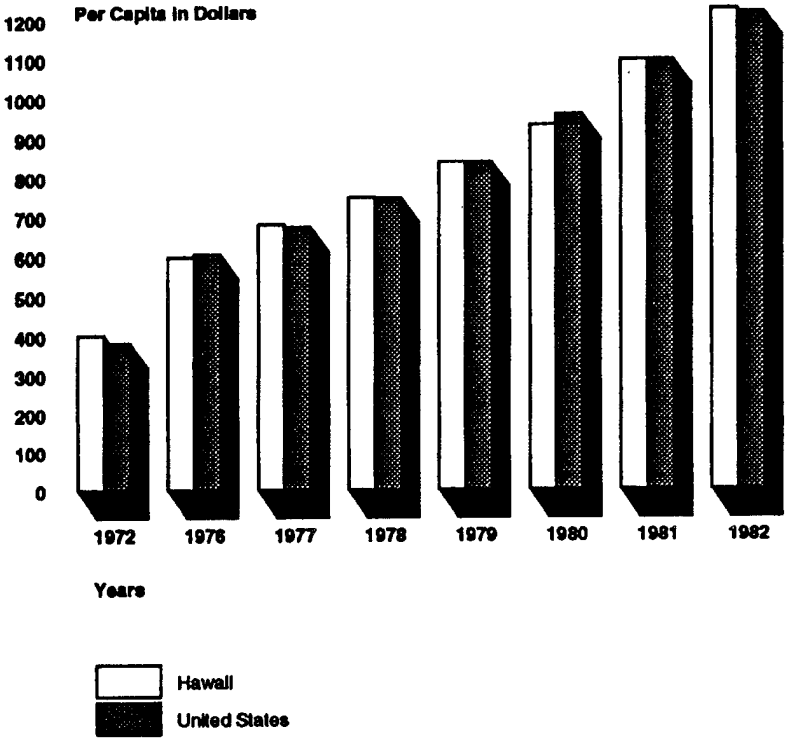
Hawaii Matches National Health Care Costs While Expanding Access

Hawaii has not been immune from the national trend of rising health care costs. Hawaii's per capita health care expenditures from 1974 to 1982,[10] however, tracked the national average at the same time the state widened access to health care coverage through its employer mandate (see fig. 2.1).

[9]One reason for this access problem is that physicians receive lower reimbursement rates for Medicaid patients than for those with private health insurance or in SHIP.

[10]Comparable data are not available after 1982.

Figure 2.1: Hawaii Tracks National Health Care Expenditures (1972-82)



Note: Expenditure data are not available after 1982.

Source: Health Care Financing Administration.

Small businesses in Hawaii pay less for health insurance than their counterparts in many other parts of the country. The lower premiums are the result of several factors, including policies of the state government, characteristics of the insurance industry, and practices of private insurers. The state government's decision to apply the Prepaid Health Care Act to virtually all employers resulted in fewer uninsured people and, therefore, less uncompensated care with its attendant cost shifting and cross-subsidies. Another policy reducing the need for uncompensated care is that insurers must cover all employees in a group, regardless of medical condition or risk. The domination of the Hawaii market by two insurance companies strengthens their ability to negotiate favorable reimbursement rates and contributes to the lower rates in Hawaii.

An additional factor leading to lower premiums is that the two dominant insurers voluntarily established an adjusted community-rating[11] system. Hawaii's small businesses (companies with fewer than 100 employees) are placed in one large risk pool, but are assigned to bands on the basis of their utilization experience. The insurer calculates a base rate for the entire pool, then adjusts premiums up or down by up to 20 percent for the different bands. This system allows small employers to offer their employees health care benefits comparable to those offered by large ones. The Prepaid Health Care Act facilitated the use of community rating by requiring that all employees covered by the act obtain insurance, thus preventing healthy people from opting out of the system.

ERISA Exemption Key Factor Shaping Hawaii's Approach to Universal Access

Hawaii's statutory exemption to ERISA is the key factor that enabled Hawaii to fashion its approach to universal access. The fact that the Prepaid Health Care Act was already in place when ERISA took effect was probably an important factor in the Congress's subsequent legislation that exempts the act from ERISA's preemption clause.[12] Without that exemption, Hawaii would not be able to require all employers, including those that self-insure, to provide the full package of benefits mandated by its law, and would be deprived of the cornerstone of its strategy for achieving universal access.

Several factors influenced the specific design of Hawaii's Prepaid Health Care Act and the state's ability to implement it successfully. Hawaii's decision to require all employers, without distinction by number of employees, to provide insurance created an even playing field that did not put some businesses at a competitive disadvantage. The Hawaii system minimized the problem of some businesses carrying a disproportionate burden of health care costs.

[11]When insurers use community rating, they base premiums on the anticipated health care utilization of all subscribers in a particular geographic area or other broad grouping. This contrasts with the prevalent practice of experience rating, in which insurers base premium rates on the medical experience of each insured group.

[12]The Prepaid Health Care Act took effect in June 1974 and ERISA, in September 1974. In 1976, Hawaii amended its law to expand the standard benefits package to include mental health, substance abuse, and other services. This prompted the Standard Oil Company to challenge the applicability of the Prepaid Health Care Act to self-insured employers, and in 1981 the Supreme Court upheld a lower court decision that found that ERISA preempted the state's ability to impose the requirements of the act on self-insured companies. Standard Oil Company of California v. Agsalud, 633 F.2d 760 (9th Cir. 1980), aff'd mem., 454 U.S. 801 (1981). In 1983, Hawaii's congressional delegation obtained legislation to exempt Hawaii's Prepaid Health Care Act from the ERISA preemption provision. The exemption, however, applies only to the Prepaid Health Care Act as it was enacted in 1974, thus precluding Hawaii from substantively amending the act.

Other economic and social conditions have affected the continued viability of Hawaii's system. The unemployment rate in Hawaii is low,[13] so that many employers might offer health benefits to attract employees regardless of the legal requirement. When Hawaii mandated coverage by employers, there was already a tradition of employer-provided coverage, due partly to the strong role of labor unions in the work force and partly to Hawaii's history of plantation medicine.[14] Additionally, Hawaii's island status may have diminished the likelihood that employers or physicians would flee to neighboring states or that people with expensive medical conditions would move in.

An important factor in Hawaii's ability to create a program to extend coverage to its gap group was the relatively small size of its uninsured population, resulting from the combined effects of its employer-mandated insurance and expansive Medicaid program. In selecting an approach for increasing access, Hawaii followed the example of Washington's Basic Health Plan, which offers state-subsidized health insurance to low-income residents.[15] (See chap. 3 for a discussion of Washington's program.)

Hawaii Needs Federal Legislation to Refine System

Hawaii officials believe they have made great progress in their quest toward achieving universal access, but they also recognize the need for improvements to the effectiveness and equity of the state's system for ensuring access to health care coverage. Although Hawaii has surpassed other states in expanding access to almost all of its residents, a small percentage of the population remains uninsured. In addition, there is significant variation in the coverage available to beneficiaries of Hawaii's three separate programs, particularly between the SHIP program and the employer and Medicaid plans.

The statutory exemption from ERISA is specifically limited to the provisions of the original 1974 Prepaid Health Care Act. The state cannot modify the mandated benefit package, require coverage for dependents, or change the

[13]Hawaii's unemployment rate was 2.8 percent in September 1991.

[14]Large plantations employed physicians to provide free health care services to their workers.

[15]The SHIP enabling legislation also permits the Department of Health to use the appropriated funds to purchase care directly, either from private clinics or Medicaid, instead of establishing an insurance program. Some policymakers and community representatives have advocated this approach.

cost-sharing formula for insurance premiums.[16] Hawaii is currently seeking amendments to ERISA to permit it to respond to implementation problems or to improve the act.

Massachusetts Struggles to Provide Universal Access Through Play-or-Pay Requirement

In 1988, Massachusetts enacted a plan to achieve universal access to health care coverage by 1992.[17] The state recognized that obtaining amendments to ERISA to enable it to require all employers to provide health insurance would be unlikely. Massachusetts officials, therefore, opted for a play-or-pay mandate for employer-provided insurance as their principal tool to expand coverage. The state supplemented this approach with a series of subsidized programs to provide coverage to residents without employer-based insurance.

The Massachusetts law expanded access to coverage in conjunction with reform of the state's hospital-financing system. Hospitals received immediate rate increases that were funded principally by private payers. Implementation of the law's access provisions has been slower, and the effective date of the play-or-pay mandate has been delayed until 1995. The funding mechanisms to expand coverage depend on a combination of public and private financing; this makes these mechanisms vulnerable to the decline in the state's economy. Moreover, anticipated savings from cost-containment measures, which were intended to help finance access expansions, did not materialize.

Public Programs Supplement Employer-Provided Insurance

The Massachusetts Health Security Act of 1988 committed the state to ensuring all state residents access to basic health care services by 1992. The law established a series of phased-in programs and hospital-financing reforms, culminating in a play-or-pay mandate for employer-provided insurance. These measures were all designed to achieve the goal of universal coverage.

[16]When prevented from amending the law to add coverage for mental health, substance abuse, and well-child benefits to the required benefits, the state circumvented this restriction by amending its insurance code to require the inclusion of these benefits in health plans sold in Hawaii. Those who self-insure, however, are not required to provide these benefits.

[17]In 1991, Massachusetts extended the date for implementation of a major part of its plan to 1995.

The centerpiece of the Massachusetts approach to universal access was a requirement that, as of 1992, employers of six or more persons[18] pay an annual medical security contribution of $1,680 per employee to help finance affordable health insurance through the state.[19] If an employer provides health insurance to its employees, it may generally deduct its costs for providing the insurance from its required medical security contribution.

The law created two transition programs to pave the way for implementation of the play-or-pay system. To encourage small employers to provide insurance to their employees, the state established a 2-year income tax credit for small businesses[20] newly purchasing health insurance. To facilitate development of the small-group insurance market and state-brokered coverage for the remaining uninsured, the law authorized the new Department of Medical Security (DMS) to test alternative methods of providing health insurance, such as using subsidies and managed care plans.

Massachusetts officials recognized that the play-or-pay mandate and state Medicaid program together would not cover the entire population; in addition, they wished to reduce dependence on the state's uncompensated care pool.[21] To do this, they established additional programs that would provide health insurance to specific groups likely to remain uninsured:

- Medicaid expansion: Medicaid income eligibility for pregnant women and infants was extended to the maximum 185 percent of the federal poverty level. The state also funds prenatal and limited postnatal care for those with incomes between 185 and 200 percent of poverty.
- Mandatory health insurance for college students: All students who are full-time or three-quarters-time must have health insurance that provides minimum benefits. Before this provision went into effect, in September 1989, an estimated 32,000 college students in the state did not have a prepaid health plan.

[18]In addition to exempting employers of five or fewer employees and the self-employed, the law exempted employers from making contributions for part-time (under 20 hours a week) and temporary employees and those with health insurance from another source, including Medicaid, Medicare, and a spouse's employer.

[19]This amount would be valid through 1992 and would be adjusted in subsequent years. The required contribution equals 12 percent of an employee's wages, up to the medical security wage base, which was set at $14,000 for 1992.

[20]Defined in this context as businesses with 50 or fewer employees.

[21]The uncompensated care pool compensates hospitals for their bad debt and charity care. It is funded by a uniform statewide surcharge on private-payer hospital bills.

- Health Security Plan (HSP) for the unemployed: HSP offers health insurance to residents who are collecting unemployment benefits and whose family income is below 400 percent of the federal poverty level.[22] The plan, financed through an unemployment health insurance tax on employers,[23] (1) provides direct health insurance coverage or (2) subsidizes premiums of those who pay to continue coverage they had while employed, such as under COBRA[24] requirements. The plan has served about 55,000 people, half of them unemployed and the remainder their dependents.
- CommonHealth programs for disabled children and disabled working adults and for welfare recipients entering the work force: CommonHealth offers disabled children and working adults either a full health insurance package with benefits comparable to Medicaid[25] or a supplemental package for those with health insurance that does not cover all their needs. Enrollees with incomes of at least 200 percent of poverty pay a sliding scale premium. At the end of 1991, the program was serving 1,532 adults and 1,222 children.

  The program for welfare recipients entering the work force diminished in importance after 1989 federal legislation extended Medicaid benefits to certain AFDC recipients entering the work force.[26] The state program, enrollment for which has dropped from a peak of 4,500 enrollees to fewer than 1,000, is due to expire in 1992.

- CenterCare Program for low-income residents: The DMS established CenterCare to offer primary health care services to the low-income (below 200 percent of poverty) uninsured. Community health centers receive capitation fees for enrolling participants and providing ambulatory services to them.

  The Massachusetts law also included cost-control provisions intended to produce savings to help finance these access expansions. These cost-containment features included policies to induce hospital closings

[22]This cap became effective March 1, 1992; originally, the limit was 300 percent of poverty.

[23]The maximum annual contribution is $16.80 per employee.

[24]For firms with 20 or more employees, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272) requires that employers offering health insurance benefits offer certain employees separating from the firm the option of continuing health coverage, for a period varying from 18 to 36 months, depending on the reason for separation. The employee may be required to pay for the premium, which may be no higher than 102 percent of the group rate.

[25]CommonHealth providers receive the same reimbursements as those for Medicaid services, and generally the same providers serve both populations.

[26]Omnibus Budget Reconciliation Act of 1989, P.L. 101-239.

and reduction of excess hospital beds, as well as support for DMS reliance on managed care in its programs.

Economic and Budgetary Problems Delay Achievement of Access Goals

Massachusetts will not meet its original goal of providing access to health care for all residents by 1992. In response to a decline in the economy, legislation passed in 1991 postponed implementation of the play-or-pay requirement until 1995. While the state will not immediately attain universal access, it has succeeded in extending coverage to those enrolled in the special population programs. Some of these programs, too, however, have been limited by budgetary constraints.

State Achieves Limited Expansion of Coverage With Targeted Programs

The state has made partial progress in expanding access through its programs for special populations. Only a small proportion of the state's approximately 483,000 uninsured, however, are eligible for these programs, and some of the programs do not serve all who qualify for participation. Those that continue to lack health care coverage include employees whose employers do not offer health insurance, the self-employed, people who are not working, and others who cannot afford private coverage and do not qualify for the targeted state programs.

Because of budgetary constraints, enrollment goals for programs designed for special populations are sometimes limited by appropriation levels that are insufficient to serve the eligible group. For example, there has never been a good assessment of the number of disabled children and adults eligible for the CommonHealth program. After the first year, program managers stopped setting enrollment goals and focused instead on managing the program within its appropriation.

Funding considerations may also affect the coverage these programs provide. For example, due to limited funding, the HSP for the unemployed was designed with large copayments and deductibles. When enrollment and participation were lower than anticipated, resulting in a surplus in the program fund, state officials reduced the deductibles from $1,200 to $300 for inpatient hospital care and from $300 to $150 for major medical services (including prescription drugs and outpatient hospital care).[27] Members are charged $25 for each physician visit and 50 percent of outpatient hospital costs.[28]

[27]The major medical deductible is capped at $300 a family.

[28]There are no deductibles or copayments for prenatal and well-baby care.

Uncertainties Undermine Initiatives to Prepare for Play-or-Pay

In moving to a play-or-pay mandate, Massachusetts officials hoped to encourage most firms to offer insurance to their employees rather than pay the tax. Recognizing the problems of affordability and availability of health insurance for small businesses, the state created the tax credit and other initiatives to improve the functioning of the small business market. (See chap. 4 for a discussion of problems in the health insurance market for small businesses.) An ailing economy, coupled with lack of certainty regarding when—and perhaps if—the play-or-pay mandate will take effect, has limited the success of these efforts to initiate a gradual transition to a play-or-pay system.

It is too early to evaluate the effectiveness of the small business tax credit in inducing employers to offer health insurance.[29] Members of the business community, however, are skeptical about the credit's value as an incentive. They believe it may have limited effectiveness because of insufficient availability of affordable policies, the reluctance of employers to pay premiums long before receiving the benefit of the tax credit, and concerns about the temporary nature of the program.[30]

Similar constraints led to disappointing results from the DMS phase-in initiatives to test alternative methods of providing health insurance, intended to make it easier for small employers to offer coverage and to facilitate implementation of the state-brokered insurance plan. The department expected to enroll 7,500 people through its first set of contracts with insurers, but provided coverage to only 1,100 people.

State budgetary problems, uncertainty about the future of the play-or-pay mandate, and businesses' fears associated with the recession, DMS officials believe, were responsible for the low enrollment. These concerns were echoed by members of the business community, who were skeptical about the state's ability to continue subsidizing coverage and were reluctant to offer employees benefits employers might later have to rescind. Administrators terminated the phase-in initiatives program in January 1992, due to lack of funds, after the governor's 1991 budget cut $8 million from the original appropriation of $11 million.

Funding Sources for Access Expansions Inadequate

Massachusetts's ability to fund its access expansion hinged on both continued economic growth and containment of rising health care costs.

[29]Returns for tax year 1990 may be submitted as late as 1992, and state officials have not yet analyzed data on use of the credit.

[30]A business may use the tax credit for 2 years, and the tax-credit program is to expire at the end of 1992.

Massachusetts has the highest per capita health care expenditures in the nation; its hospital expenditures are also higher than any other state's.[31] Nevertheless, at the same time the Health Security Act committed the state to expanding access through a combination of public and private spending, it obligated more funding for hospitals.

The funding mechanisms built into the Health Security Act made it easier to increase hospital revenues than to expand access to health insurance. The law allocated most of its new funds to hospital reimbursement. While increased hospital rates went into effect immediately, increased access was dependent on annual appropriations that are vulnerable to fluctuations in the state's economy and the political climate.[32] The downturn in the Massachusetts economy increased the importance of the law's cost-containment provisions as a means of financing the access provisions. These provisions, however, have not yielded the expected savings.

Economic and Political Factors Shape Massachusetts Access Plan

Several factors influenced the design of Massachusetts's initiative to expand access to health care coverage. The Health Security Act was the product of (1) negotiations with a range of interest groups; (2) the availability of state funds following a period of economic growth; (3) a low uninsurance rate, due partly to an expansive Medicaid program; and (4) the effect of federal ERISA restrictions.

The Massachusetts plan reflected the interests of several parties with a stake in a law that simultaneously expanded access and reformed hospital financing. For example, businesses wished to escape their growing liability for uncompensated care, and the act capped the liability to the state's uncompensated care pool of private sector payers for hospital services; the act also tried to reduce the need for uncompensated care. Hospitals had an interest in being reimbursed for care provided to the uninsured, and consumer groups wished to preserve and expand access to health care for the uninsured.

[31]In 1990, Massachusetts's estimated per capita health care expenditure was $3,031; the estimated U.S. average was $2,425. In 1989, Massachusetts's per capita hospital expenditure was $1,042; the U.S. average was $745.

[32]For further discussion of this point, see Alan Sager, "Making Universal Health Insurance Work in Massachusetts," Law, Medicine & Health Care, Vol. 17 (Fall 1989); and "Promise and Performance," First Monitoring Report of Access and Affordability Monitoring Project, Boston University School of Public Health (April 1989).

At the time the plan was enacted, economic growth had increased state revenues. The Massachusetts package depended on the availability of state funds to (1) finance costs that exceeded a new private sector cap for the uncompensated care pool, (2) fund some of the insurance programs for special populations, and (3) subsidize the cost of health insurance for residents not covered by employers under the play-or-pay mandate. The state's low uninsurance rate, which had fallen to one-quarter below the U.S. average, meant new programs had to reach fewer people.

ERISA Restrictions Dictate Play-or-Pay Structure of Employer Mandate

Finally, Massachusetts's specific approach to achieving universal access—the play-or-pay requirement—resulted directly from limits on the state's choice of strategies caused by the ERISA preemption provision. Governor Michael Dukakis, seeking to provide coverage to the uninsured population without violating his "no new tax" pledge, planned to request that the U.S. Congress amend ERISA to permit Massachusetts to do what Hawaii can do—require employers to provide minimum health insurance to their employees. When others in the state withheld support from this plan because of indications that there was little chance of obtaining the needed federal legislation, he turned his support to the play-or-pay approach.

The play-or-pay provision is framed as an exercise of the state's taxing power; all employers subject to the requirement must pay the tax, but they are permitted to take as a credit the expense of providing health insurance coverage. State officials are unsure whether this approach will withstand a legal challenge based on ERISA.

Future of Massachusetts Plan Uncertain

The Massachusetts initiative to achieve universal access is in a continual state of flux. The biggest question mark is the future of the play-or-pay mandate. Postponement of implementation until 1995 represented a victory for proponents of the employer requirement over those who worked for its repeal, but support for repeal continues in the current administration and the business community.

New legislation enacted at the end of 1991 revised the hospital-financing system established by the 1988 Health Security Act. The legislation also included provisions to reform the health insurance market for employers of 25 or fewer people. State officials hope these reforms, aimed at increasing the availability and affordability of insurance, will encourage more small businesses to purchase coverage. (See chap. 4 for a discussion of the experience of other states that have enacted such reforms.)

Oregon Attempts Interdependent Public and Private Approach to Universal Access

In 1989, Oregon enacted the Oregon Health Plan, to extend access to health coverage to most uninsured residents. Within the context of a limited state budget, state officials designed the following three programs:

- an expanded Medicaid program that covers more people but curtails some services,
- a play-or-pay mandate that requires employers to contribute to a state insurance pool fund if they do not provide health insurance, and
- a risk pool to cover those unable to obtain insurance because of preexisting medical conditions.

A fourth component was added in 1991, when Oregon enacted legislation to help small employers provide group health insurance.

The state faces uncertainty, however, about its ability to realize its plan. Oregon cannot fully implement this plan unless HCFA approves the demonstration project and waives a number of Medicaid requirements. Further, Oregon officials expect that additional state legislation will be needed for the play-or-pay mandate to be effective. Finally, if that mandate is implemented, Oregon would then face the possibility of a legal challenge based on ERISA.

Oregon Plans to Expand Access by Broadening Medicaid Eligibility

Oregon's planned Medicaid demonstration would extend Medicaid eligibility to all state residents with incomes at or below the federal poverty level. In contrast, the existing program excludes certain population groups, such as single adults, and in most cases limits income eligibility to 50 percent of poverty.[33] A majority of Medicaid recipients would obtain treatment from managed health care systems rather than fee-for-service arrangements. State officials plan to implement the expansion through a 5-year demonstration project, starting in July 1992. It will cost the federal government over $100 million in additional matching funds during the years of the demonstration.

One of the most controversial aspects of the Medicaid expansion plan is the redefinition of reimbursable health care services, based on a process of setting medical priorities. A state commission ranked 709 services, in descending order, on the basis of which contribute most to quality of life and reduced mortality. Under the demonstration project, the state legislature would assess available state funding and define how many

[33]Certain groups have higher Medicaid income eligibility caps. For example, Oregon's Medicaid program caps eligibility for pregnant women at 133 percent of poverty. Under the demonstration, such limits would not be reduced.

categories of service the state Medicaid program could afford to reimburse.[34] Services above the cut-off point would make up the standard benefits package and be eligible for Medicaid reimbursement.

For the first year of the demonstration project, the state legislature has approved a standard benefits package that includes the top 83 percent of the 709 services on the priority list.[35] In order to implement the Medicaid expansion, Oregon must secure federal approval of the proposed project. In August 1991, Oregon requested that HCFA waive 11 categories of federal Medicaid requirements so that the state can receive federal Medicaid matching funds under the demonstration. HCFA officials are expected to decide in June 1992 whether to approve Oregon's proposal.

Employment-Based Insurance and High-Risk Pool Cover Remaining Uninsured

Starting in July 1995, the Oregon Health Plan requires all employers who do not provide employer and dependent health care benefits to contribute to a state Insurance Pool Fund.[36] This play-or-pay mandate will take effect, however, only if the state is able to implement the Medicaid component of the plan.[37] Under the play-or-pay system, Oregon employers would be subject to a payroll tax[38] unless they offered health insurance to permanent employees and their dependents.[39] State officials expect that employers would be required to provide coverage at least comparable to the Medicaid standard benefits package.

Tax revenues generated through the program would fund coverage for uninsured workers. As of late 1991, state officials had not established administrative mechanisms for collecting and disbursing the payroll tax

[34]Every 2 years, the state commission would review and update the priority list and then present the revised list to the legislature for funding.

[35]The legislature may not alter the order of services on the priority list. Lawmakers must eliminate reimbursable services by starting at the bottom and moving up the list. The standard benefits package funded for the first year excludes services such as treatment for infertility and a viral sore throat, routine screening for adults not at special risk for a condition, and aggressive treatment for end-stage AIDS and cancer. The package is more limited than current Medicaid benefits for some conditions—such as certain types of back sprains—but it includes some services not currently covered—such as adult dental care.

[36]Under the original 1989 legislation, this requirement was to take effect in January 1994. In response to business groups' concerns, however, the 1991 legislature postponed the effective date to July 1995.

[37]The original 1989 legislation did not include this provision. Supplementary 1991 legislation conditioned implementation of the play-or-pay mandate on the Medicaid expansion.

[38]The payroll tax would be equivalent to 75 percent of the cost of a basic benefits package for each employee and at least 50 percent for dependent coverage, as determined by the Insurance Pool Governing Board.

[39]The law would apply only to employees working an average of at least 17.5 hours a week.

revenues. Legislative staff and program administrators acknowledge that many details and policy considerations are not yet resolved.

The play-or-pay mandate will not go into effect if 150,000 previously uninsured employees obtain coverage by October 1993. To encourage small businesses (25 or fewer employees) to provide coverage, the state offers tax credits through the state's Insurance Pool Governing Board to small employers that have not recently offered health coverage. To be eligible, an employer must pay a minimum of $40 per month toward the premium for each enrolled employee. The plans include coverage for most physician and hospital services. Plans offering coverage for dependents or preventive care are available at an additional cost.[40] The number of employees that obtained coverage between 1989 and 1991 was less than 4 percent of the 150,000 whose acquisition of insurance by October 1993 would stop the play-or-pay mandate from taking effect.

The third component of the Oregon Health Plan is the state's high-risk pool. It serves Oregon residents who are ineligible for Medicare or Medicaid and cannot obtain insurance because of a medical condition. The pool is funded by individual premiums, set at 150 percent of the average premium of comparable plans sold by the five largest insurers, and by insurer assessments. A state board solicited bids for an administering carrier, established the benefits package offered by the pool,[41] and oversees administration of the program.

Oregon Health Plan Promises Near-Universal Access to Coverage

Oregon officials predict that complete implementation of the Oregon Health Plan would decrease the number of uninsured residents from about 15 percent of the state's population to about 3 percent. Almost all of the newly insured would be covered through the Medicaid expansion, employer-provided health insurance, or the state Insurance Pool Fund. The high-risk pool is expected to cover a maximum of 4 percent of the estimated uninsured population.

The potential impact of the Medicaid expansion on access to coverage is affected by the impact of the play-or-pay mandate. Overall, state Medicaid officials predict, complete implementation of the Oregon Health Plan

[40]The basic plans cost $53.33 a month to cover the employee only. Insurers do not have to offer state-mandated benefits, but generally they do. Instead of limiting benefits, most carriers support low premiums by charging high deductibles and copayments. For a higher price, employees can buy policies that cover dependents and charge lower deductibles and copayments.

[41]The administrator of the high-risk pool expects that future benefits may mirror the state Medicaid package, but as of yet there is no such statutory requirement.

would extend health coverage to over 330,000 of the 1991 estimate of 415,000 uninsured residents. By the fifth year of the demonstration project, the state estimates, Medicaid would cover 90,400 additional persons with incomes below the poverty level, or 36 percent more than the existing program would cover. This total takes into account an expectation that the play-or-pay mandate would reduce Medicaid enrollment by about 30,000, as that portion of the Medicaid population obtains employer-based coverage.

State officials anticipate that the employer play-or-pay mandate will cover about 240,000 workers and dependents, but they caution that estimates of employer-based coverage are uncertain. As of August 1991, the high-risk pool covered about 1,600 of an estimated 15,000 eligible state residents.

Even under full implementation of the Oregon Health Plan, some Oregon residents would remain uninsured. These groups would include

- people eligible for Medicaid who choose not to enroll in the program;
- part-time, seasonal, and temporary workers; and
- the unemployed with incomes in excess of the federal poverty level.

Standard Benefits Package Would Form Basis for Coverage

The Medicaid component of the Oregon Health Plan emphasizes access to basic health benefits, defined as those services covered by the Medicaid demonstration project's standard benefits package. State officials expect that the Medicaid standard benefits package would also become the norm for employer-provided health insurance, although some employers might choose to offer a richer benefits package.

The package funded for 1992 has been generally well received by Oregon's medical community, although there are concerns that it could be reduced in the future because of budgetary constraints. The standard benefits package emphasizes preventive care, diagnostic services, and treatments that significantly expand lifespan or improve the quality of life. The package does not cover conditions for which treatment is ineffective or futile. Comfort care for patients suffering these conditions, however, ranks high on the priority list.[42]

[42]Policymakers decided to exclude mental health and chemical dependency benefits from the priority list for the first year of implementation, pending further research on how to weigh them against other services. The state plans to integrate these benefits into the list by 1993.

Fully Reimbursed Managed Care Would Help Guarantee Medicaid Recipients Access to Care

The Medicaid component of the Oregon Health Plan includes provisions designed to help ensure public assistance recipients access to care, not just access to coverage. Because some providers are reluctant to serve the Medicaid population, Oregon's Medicaid demonstration project would rely on managed care providers and is committed to fair reimbursement of these providers.

Medicaid recipients enrolled in prepaid managed care are restricted in their choice of health care provider. Access can be improved by such an arrangement, however, because a provider is guaranteed to the recipient, whereas under traditional Medicaid fee-for-service arrangements this is not the case. By pledging to reimburse managed care providers at a rate keyed to actuarial analysis of the cost of service, Oregon would also seek to address providers' concerns about Medicaid's typically low reimbursement levels.[43]

Oregon Health Plan Will Require Additional Funds, but Some Savings Are Expected

State officials predict that under the 5-year Medicaid demonstration project, they will be able to insure 36 percent more people for an increase in cost of 4 percent over what the existing Medicaid program would require. This estimate of a $238.3 million Medicaid cost increase to the state and federal governments[44] reflects the expectation that some new costs will be offset by savings associated with managed care and limits on reimbursable benefits. Some analysts, however, question the likelihood of limiting cost increases to this extent.[45]

If the play-or-pay mandate takes effect in 1995, additional savings are expected to accrue to the state and federal governments. At that time, about 30,000 people who would otherwise become eligible for Medicaid are expected to forego publicly assisted health coverage for employer-based insurance.

It is too early to estimate how much more the state's employers and employees will pay under the play-or-pay mandate, state officials say.

[43]For a detailed discussion of Oregon's managed care program and GAO's work on Medicaid managed care in general, see Managed Care: Oregon Program Appears Successful but Expansions Should Be Implemented Cautiously (GAO/T-HRD-91-48, Sept. 15, 1991) and Medicaid: Factors to Consider in Expanding Managed Care Programs (GAO/T-HRD-92-26, Apr. 10, 1992).

[44]The federal government will bear just over half of these additional costs; the state will pay the balance.

[45]For example, costs could rise if the state Medicaid agency was unable to develop an adequate managed care delivery system and thus fail to capture the savings associated with capitated provider arrangements.

Some observers contend that employers will face additional costs, amounting to an 8 to 9 percent payroll tax, which may force some businesses to reduce their number of employees or leave the state. In contrast, state officials believe Oregon business as a whole will benefit because mandated coverage will mitigate the burden associated with cost shifting.

Fiscal, Legal, Political Factors Influenced Approach

State budget constraints were a major factor shaping the design of the Oregon Health Plan. Limits on state funds coupled with limits on the public's willingness to accept new taxes dictated the need for an approach funded not only by the public sector, but by employers and employees as well. Furthermore, recognition that state resources were limited contributed to the policymakers' decision to expand coverage to part of the uninsured population through Medicaid, thus using federal matching funds to help finance additional coverage, and to limit reimbursable benefits to help pay for the expanded eligibility.

Federal ERISA constraints also influenced Oregon's strategy. Although Oregon health policy analysts favored requiring all employers to provide employee benefits, as Hawaii does, analysts recognized that this approach would violate the preemption clause of ERISA. Oregon officials opted for a tax-based play-or-pay approach with the hope that it could withstand an ERISA challenge.

The need for political compromise also affected the design of the Oregon Health Plan. To rally sufficient support for the authorizing legislation, proponents assembled a broad coalition, including medical organizations, labor, business groups, and consumers. A key tactic was to craft a link between public and private sector mechanisms to expand access to coverage. To help equalize benefits offered to the poor under Medicaid and those available through private insurance, the legislature required that plans available through the Insurance Pool Governing Board must be substantially similar to the Medicaid standard benefits package. Furthermore, the president of the state senate expects that the standard benefits package would serve as the minimum standard not only for Medicaid, but also for employees and dependents gaining coverage under the play-or-pay mandate.

Political considerations also engendered supplementary 1991 legislation to refine the 1989 three-pronged approach. For example, the 1991 legislature further emphasized the link between the public and private components of

the Oregon Health Plan by conditioning the play-or-pay mandate on implementation of the Medicaid expansion. In addition, the 1991 legislature responded to small employers' concerns by enacting a program for businesses that employ between 3 and 25 people. The program regulates the insurance market to improve availability and affordability of insurance for small businesses.

Future Impact of Oregon Health Plan Hinges on Uncertainties

The central uncertainty facing the Oregon Health Plan is whether HCFA will approve the Medicaid demonstration project. In August 1991, the state petitioned HCFA to grant waivers from a number of federal Medicaid regulations, including those affecting

- choice of providers—allowing the state to restrict each demonstration beneficiary to a single health plan;
- income and categorical limitations—allowing the state to expand Medicaid eligibility beyond federal limits and to disregard assets in determining eligibility; and
- amount, duration, and scope of services—allowing the state to deny coverage of services that fall below the standard benefits package on the priority list, even though Medicaid requires coverage of those procedures.

The state would like to begin its demonstration project in July 1992, but HCFA has indicated it will not reach a decision on the waiver application before June 1992. If the federal government grants the necessary waivers and provides the needed funds, Oregon's ability to implement the Medicaid demonstration project (and, indirectly, the play-or-pay mandate) will hinge on its capacity to fund the Medicaid expansion to the level that HCFA has authorized.

Consumer groups critical of the Oregon Health Plan contend that future limitations on funding would cause the Oregon legislature to restrict reimbursable benefits to an unacceptable level. Oregon's governor expects that any substantive change to the benefits package, however, would require further federal approval through an amendment to the waiver, thus ensuring that the state would not restrict benefits unilaterally. In addition, she has pledged to withdraw the waiver request, thereby cancelling the Medicaid demonstration project, if the state deems that the benefits package for the poor would drop to an inadequate level.

Implementation of the Medicaid demonstration project is not the only hurdle facing Oregon. Despite efforts to avoid violating the ERISA

preemption clause by reliance on the state's power to tax, the courts may rule that the play-or-pay mandate violates ERISA. Business leaders reported to us that a legal challenge to the mandate is inevitable.

A final uncertainty relates to the play-or-pay mandate's potential for effectiveness in the absence of further clarifying legislation. For example, there is disagreement about whether employees will be able to decline coverage offered under the play-or-pay mandate and whether employers will have to contribute a minimum portion of the monthly premium costs. Legislative intent was to compel employees to accept coverage and to specify employers' contribution levels, according to state officials, but they recognize that stronger legislation will probably be needed to bring about these intentions.

Recent Developments in State Activity

Proposals for comprehensive reform to achieve universal access are continually developing in the states. Minnesota, Florida, and Vermont recently enacted legislation setting a goal of universal access and establishing procedures for achieving that goal. Additionally, most states have commissions to explore methods for expanding access to coverage. States continue to face the same difficulties in crafting their universal access initiatives—competing political interests, strained budgets, and potential federal constraints. Both Minnesota and Florida may seek exemptions from the ERISA preemption clause to implement their plans or give them flexibility for future action.

Minnesota Enacts Health Right Act to Expand Access and Control Costs

Minnesota recently passed the Health Right plan, which phases in several programs to extend access to health insurance to many of the state's uninsured. Key features of the act include

- creation of a state Health Care Commission to devise for the legislature's consideration a plan for reducing the growth of health care expenditures by 10 percent a year for 5 years;
- insurance market reforms to make health insurance more affordable and available to small businesses;[46] and
- a state-subsidized, managed care health plan for residents not eligible for Medicaid and with incomes below levels that are approximately equal to 275 percent of the federal poverty level.

[46]See chapter 4 for a discussion of problems in the health insurance market for small businesses.

The health plan opens enrollment to children and their families for outpatient services in October 1992 and for the full plan in July 1993.[47] Enrollment for those without children will begin in July 1994. Sliding scale premiums will range from 1.5 to 8.8 percent of income; a system of copayments and out-of-pocket limits will also be based on income. Annual inpatient benefits for adults are capped at $10,000.

The funding mechanism for the Health Right Act is a 5-cent increase in the state cigarette tax and a phased-in provider tax: (1) a 2 percent gross revenue tax on hospitals (effective 1993) and on physicians and other health care providers (effective 1994) and (2) a 1 percent tax on HMOs and nonprofit health service companies (effective 1996). Hospitals may pass the tax through to payers during 1993. Minnesota officials decided to use a provider tax so that financing would come from within the health care system. Another factor considered was that a provider tax affects all participants in the health care system. Because of the ERISA preemption clause, other financing mechanisms, such as a premium tax, would leave out the self-insured.

Plan Builds in Cost Containment Efforts

Members of Minnesota's new statewide Health Care Commission are to represent consumers, employers, health plans, health care providers, unions, and state agencies. The commission will be responsible for setting limits on growth rates of health care costs, overseeing new technology and procedures, instituting uniform claims and procedures, and assisting in the planning of future health care delivery. The act's additional cost control features include (1) an increase in the state's purchasing power by requiring providers who accept clients from one state program to accept clients from all state programs and (2) the collection of data on health care practices to support implementation of practice parameters.

Florida Establishes Universal Access Goal

Florida enacted legislation in March 1992 that set a December 31, 1994, goal for universal access to a basic health care benefits package. It created the Agency for Health Care Administration to develop a plan with specific goals and timetables for ensuring access, cost containment, and insurance reform. The role of employers will be examined, and the agency is authorized to consider seeking federal changes to ERISA to permit Florida to regulate health benefits plans of self-insured employers. In addition, Florida may seek changes to the Medicare program to permit state

[47]The state plans to focus initial outreach efforts on children enrolled in Minnesota's Children's Health Plan, described in chapter 3.

administration of benefits and to the Medicaid program to permit coverage for low-income people who are now categorically ineligible for Medicaid.

Vermont to Study Single-Payer and Multiple-Payer Systems

Vermont recently enacted a law that establishes a state policy of universal access to health services and initiates a series of steps to carry out that policy. The bill creates a Vermont Health Care Authority Board and requires the board to

- adopt a health resource management plan for the distribution of health services in the state;
- adopt a nonbinding health care expenditure target for all services provided by health care facilities and providers in Vermont in fiscal year 1994;
- adopt, beginning in fiscal year 1995, an annual unified health care budget for the state; and
- submit to the legislature, by November 1993, two reports, one containing recommendations for a universal access plan based on the concept of regulated multiple payers and the other containing recommendations for a plan based on the concept of a single payer. Both plans would include uniform benefits for all residents, binding expenditure caps, and controlled capital expenditures.

Washington Explores Universal Access Options

A publicly financed single-payer system is an approach for providing universal access to health services that is under consideration in a number of states besides Vermont.[48] Washington is one state in which this approach has been proposed, and its experience in considering this and other potential methods of achieving universal access illustrates the complexities of formulating a plan for comprehensive coverage.

Single-Payer Hearings Generated Debate on Approach to Universal Access

Debate about reforming the health care system in Washington intensified during 1989 legislative hearings on a bill to establish a commission to study how to implement a single-payer system[49] with global budgeting. The bill specified a financing system consisting of (1) government contributions that would include all state and federal sources, such as Medicare, Medicaid, and public employee benefits; (2) employer contributions set on a per capita basis; and (3) individual premiums based

[48]As of October 1991, legislative proposals for such a system were under consideration in at least 17 states.

[49]A single public or private administrative organization would have complete operational authority over the plan and have a uniform budgeting, billing, payment, and data system.

on family size.[50] This bill was passed by the state house of representatives in 1990, but was defeated in the senate. As a compromise, the legislature created the Washington Health Care Commission to develop recommendations for a plan to provide universal access to health services and control health care costs.[51]

Once the single-payer initiative garnered enough support to clear one house of the legislature, the full range of interest groups entered the debate. Representatives of employers, insurers, providers, and health care consumers all began to take positions on the issue. While a consensus on the need for universal access developed, there was less agreement on the best method to achieve that goal. A key point at issue was the extent of the role of the government in controlling and regulating the health care system.

Single-Payer Proposal Modified in Attempt to Reach Consensus

In the hope of gaining widespread support for their model, sponsors of the single-payer initiative have periodically modified their proposal to enlarge the role of private insurers. The most recent version, introduced in 1992, would allow for multiple payers, including private insurers, but would retain a minimum benefits package and premium structure set by a governmental commission. It would also include a global budget for health care. The bill was passed by the house of representatives, but not by the senate.

Legislators Await Report of Health Care Commission

The Health Care Commission is scheduled to report its final recommendations to the legislature in late 1992. Its December 1991 interim report indicated that the commission has agreed on the need for universal access to a uniform set of benefits; financing responsibilities shared by government, employers, and individuals; and an independent state board or commission to define basic benefits and control costs. However, commission members have not yet agreed on a financing mechanism or defined a minimum benefits package. Most of the options under consideration would require waivers from HCFA and other federal action to allow integration of Medicaid and Medicare funds into the statewide plan.

[50]Low-income families would pay reduced or no premiums.

[51]The commission is also charged with developing recommendations to create incentives for the use of appropriate and effective health services, to reform the health care liability system, and to improve state health care purchasing.

States Expand Access Incrementally by Helping Low-Income Groups

Faced with limited budgets that make it difficult to achieve universal access to health care coverage, some states are taking a more incremental approach to expanding access. These states have identified segments of the population with greater difficulty in gaining access to health insurance, and have created programs to help these groups gain access to health care coverage. Two populations that states have targeted for special assistance are low-income children and adults.

Many of these state initiatives have succeeded in extending coverage to previously uninsured individuals, but they can be stymied by the same financial constraints as more comprehensive efforts. In most cases, states have been able to offer assistance to only a limited portion of the populations they are trying to help. States either define eligibility requirements narrowly so that many of the uninsured are beyond the scope of the program or are able to enroll only a small percentage of the eligible population.

Minnesota and Vermont Extend Coverage to Children Through Insurance and Medicaid Expansion

Providing coverage for uninsured children has become a priority for many states. One in five American children is living in poverty, and about one-third of these children are uninsured. Moreover, almost 15 percent—or over 9.5 million—of all American children lack health insurance.

The major program for insuring children from low-income families is Medicaid, which is funded with both state and federal dollars.[1] As indicated by the large number of impoverished uninsured children, however, the Medicaid program limits the number of people it will cover. Six states have developed programs using their own funds to address the problem of uninsured children who are ineligible for Medicaid.[2] (See table 3.1.) One reason states have been able to undertake such programs during a period of budgetary constraint is that taxpayers are more willing to support programs focused on children. For example, in several surveys, over 70 percent of respondents indicated that more money should be spent on health care for children as an investment in the future.

[1]Currently, all pregnant women, as well as children born after September 30, 1983, with family incomes up to 133 percent of the federal poverty level are eligible for Medicaid. States can choose to provide similar coverage to pregnant women and infants with family incomes up to 185 percent of poverty. Medicaid will expand over the next decade to include children through the age of 18 in families with incomes up to 100 percent of the poverty level.

[2]As of August 1991, Connecticut, Florida, Maine, Minnesota, New York, and Vermont were operating such programs.

Table 3.1: State-Funded Programs for Children

State	Year program operational
Connecticut	1991
Florida	1991
Maine	1990[a]
Minnesota	1988
New York	1991
Vermont	1989

Note: Only programs passed as of November 1991 are included.

[a]Maine Health Program.

State initiatives to provide health care coverage for children generally follow one of two models—they either try to give this population access to health insurance or expand access to Medicaid coverage. Minnesota and Vermont are two states that have taken these differing approaches to covering children. Minnesota created an insurance program for children from low-income families that attempts to eliminate the stigma often associated with Medicaid. In contrast, Vermont, preferring to build on its existing Medicaid system, implemented a wholly state-funded Medicaid expansion program for low-income pregnant women and children. Both programs succeed in expanding health coverage to the target population. In both states, however, many uninsured children still do not qualify for aid because of the programs' age or income restrictions.

Minnesota Expands Access to Children With Insurance Coverage

In July 1988, Minnesota implemented its Children's Health Plan.[3] This program provides health insurance coverage for uninsured children up to the age of 18 in families with incomes at or below 185 percent of the federal poverty level. The insurance is administered through the state's department of human services, which runs the state's Medicaid program, and beneficiaries may apply at numerous service offices or by mail.

Participants pay annual premiums of $25 per child, up to a maximum of $150 per family.[4] Minnesota requires no deductibles or copayments for covered services. The insurance provided by the Children's Health Plan covers primary and outpatient medical services, dental services,

[3]The Minnesota Health Right Act, passed in April 1992, provides for the phaseout of the Children's Health Plan in July 1993. It is being replaced by the Health Right Plan, which covers both children and adults (see chap. 2).

[4]Some local service agencies pay the enrollment fee for families for whom the enrollment fee is an access barrier.

prescription drugs, and certain outpatient mental health services, but not hospital inpatient care. Beneficiaries may receive covered services from any health care provider participating in the state's Medicaid program, and reimbursement to providers is based on Medicaid payment rates. Surveys of enrolled families show that 90 percent of children enrolled in the program during 1990 were able to use the same providers they had seen before enrolling.

In January 1992, the Minnesota program covered about 24,600 children. In 1990, the program's average annual cost per child was $219.[5] Originally, funding for the program came from premiums and a dedicated 1-cent increase in the state's cigarette tax. After the first year of implementation, the cigarette tax was replaced by an appropriation from state general revenues. The Minnesota legislature appropriated $19 million to fund the program during 1992 and 1993.

The Minnesota Health Access Commission estimated that in 1990, up to 67,000 children under the age of 18 were uninsured or underinsured. Plan administrators do not know how many of these children are eligible for the Children's Health Plan; they hope, however, to reach the entire eligible population. While the program has never had to limit enrollment, in September 1991 there was a backlog of 2,500 applications, or 5,000 children, because of insufficient staff to process the applications.

Program coverage is limited because no benefits are provided for hospital care. This exclusion is partly alleviated because 27 percent of the children enrolled in the Children's Health Plan have additional private insurance, generally inpatient hospital and major medical coverage.[6] Children without such coverage who require hospitalization often qualify for the Medicaid medically needy program. Program officials believe that although the Children's Health Plan allows for continuous eligibility for 12 months irrespective of changes in parental income, the program tends to serve as a temporary stop-gap for many uninsured children rather than as a long-term health insurance plan. In general, children who leave the program receive coverage from Medicaid or their parents' employer-sponsored insurance.

[5]In fiscal year 1990, the cost of health services per enrolled child was $180, and the administrative cost per enrolled child was $38.70.

[6]These plans often require a large deductible or copayment.

Minnesota Designed Insurance Program to Avoid Medicaid Stigma

Minnesota officials designed the Children's Health Plan to reach the maximum number of children, and originally made a conscious decision to separate the program from Medicaid. They wanted the program to resemble private health insurance rather than welfare because they did not want to subject it to the stigma beneficiaries often associated with Medicaid enrollment. When nearly 5,000 Children's Health Program beneficiaries became Medicaid-eligible as a result of the OBRA 1989 Medicaid expansions,[7] approximately half did not sign up—despite losing eligibility for the Children's Health Plan—because the parents (1) continued to believe that they did not qualify for Medicaid, (2) did not want to accept welfare, or (3) believed that the hassle associated with Medicaid would be too burdensome.

Minnesota officials believe that opting for this separation of public programs has created some difficulties, both because people are reluctant to transfer between the Children's Health Plan and Medicaid and because transfer is cumbersome. This is a problem for both beneficiaries and the state because Medicaid would provide eligible children with more extensive benefits and the state would receive federal matching funds for their coverage.

Vermont Covers Uninsured Children by Funding Medicaid Expansion

Vermont, another state expanding coverage to children, adopted a different strategy. In July 1989, Vermont established the Dr. Dynasaur program, using state funds to provide Medicaid-like coverage[8] to pregnant women who are not Medicaid-eligible and to children from low-income families. The program is available to pregnant women with incomes between 185[9] and 200 percent of the federal poverty level and to children under the age of 7[10] whose parents have incomes below 225 percent of federal poverty and are not eligible for Medicaid.[11] Beneficiaries cannot have health insurance from another source. Services covered by the program are the same as Medicaid-covered services, and reimbursement to providers is based on Medicaid rates. Because the program expands

[7]P.L. 101-239.

[8]Benefits are identical to Medicaid, with the exception of services intended for the elderly.

[9]Pregnant women with incomes up to 185 percent of poverty are eligible for Vermont's Medicaid program.

[10]Vermont's recent health reform law (see chap. 2) expanded eligibility, beginning in fiscal year 1993, to children under the age of 18.

[11]Eligibility depends on passing an income test, but Vermont does not require an asset test for pregnant women for either Medicaid or the Dr. Dynasaur program.

Medicaid eligibility and is administered by the state's Medicaid office, state officials can easily switch beneficiaries between Medicaid and Dr. Dynasaur coverage as family incomes change.

Dr. Dynasaur beneficiaries are currently served at an average cost of $3,750 for a pregnancy and $46 a month for a child. The program is funded by state general revenues. In fiscal year 1991, Vermont spent almost $681,000 for the Dr. Dynasaur program.

Vermont Expands Access to Uninsured Children From Families With Lowest Incomes

The Dr. Dynasaur program succeeds in providing health insurance coverage to children and pregnant women with family incomes near Medicaid eligibility levels. Many children in working-poor families with somewhat higher incomes, however, remain uninsured. One study estimated that in 1990, approximately 15,000 Vermont children were uninsured;[12] Dr. Dynasaur covers 1,200, or less than 10 percent, of the state's uninsured children. A child advocacy organization in Vermont believes that Dr. Dynasaur successfully covers the eligible, but many uninsured children over the age of 7 or whose parents' incomes are above 225 percent of the poverty level are not served.

Vermont chose to expand Medicaid because its goal was to make medical care available to low-income pregnant women and to children from low-income families who were just beyond Medicaid eligibility. Serving this population by expanding Medicaid also enabled the state to create linkages between the Dr. Dynasaur, Medicaid, and Special Supplemental Food Program for Women, Infants, and Children (WIC) programs to ensure that residents would have easy access to all federal programs for which they are qualified.

The director of the Dr. Dynasaur program does not believe that the program will undergo major changes in the near future. Now that participation has grown, however, the state plans to evaluate the program to determine if modifications are necessary.

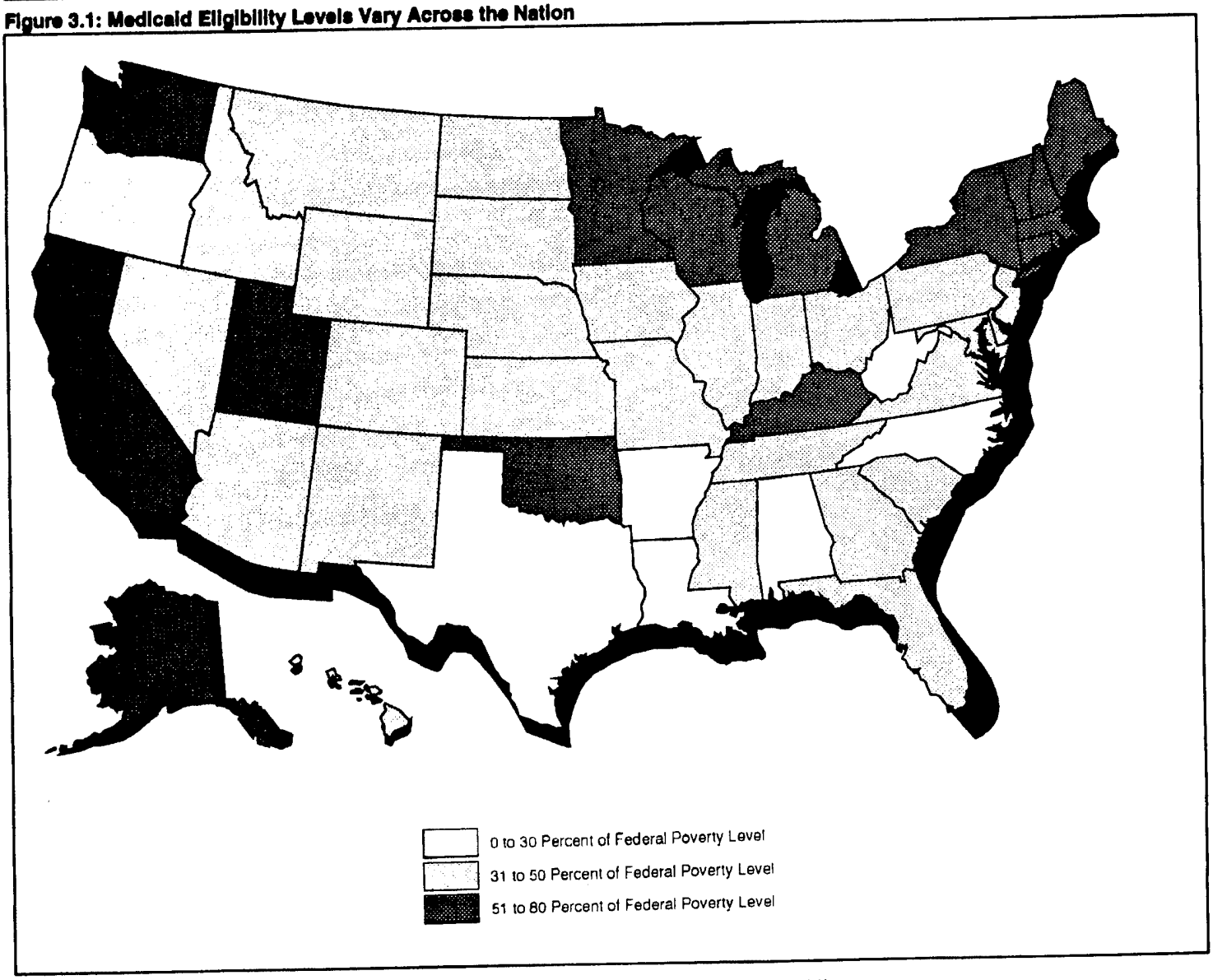
[12]Vermont Health Insurance Plan Residential Survey, 1990, Macro Market Research (Burlington, Vt.: 1990).

Washington Basic Health Plan and Maine Health Program Expand Access to Low-Income Uninsured

Low-income adults can have even greater difficulty than children in gaining access to health care coverage. Because Medicaid income-eligibility standards are so strict, many in this group earn too much to qualify for Medicaid, but cannot afford health insurance in the private market.

In 1991, the average income for a Medicaid-eligible family was $5,114 per year, or just 45 percent of the federal poverty level. Medicaid eligibility levels vary across states, but only 17 states offer Medicaid to families with incomes over 50 percent of the federal poverty level (see fig. 3.1). People living in poverty have the highest probability of being uninsured; therefore, some states have created programs to help this population obtain health insurance.

Figure 3.1: Medicaid Eligibility Levels Vary Across the Nation



Source: National Governors' Association (July 1991).

Using approaches similar to the children's programs discussed above, Washington and Maine have both implemented programs to expand access to low-income people. The Washington Basic Health Plan (BHP) provides

state-subsidized insurance coverage; the Maine Health Program (MHP) expands Medicaid coverage. While both programs have worked to provide health insurance to some low-income people, each covers less than 10 percent of the state's total uninsured population.

Washington Expands Through Insurance, Maine Through Medicaid

In 1987, Washington became the first state to authorize a subsidized health insurance program for the low-income uninsured. The BHP was distinctive because, unlike Medicaid, it incorporated features such as (1) financing through a combination of state funds and member premiums, (2) relying exclusively on managed care providers, and (3) providing basic benefits that emphasize preventive and primary care and treatment for major medical needs. The plan was authorized as a 5-year pilot project, with an original enrollment cap of 30,000, about 7 percent of the estimated eligible population.[13]

The BHP is available to those who have incomes less than twice the federal poverty level,[14] are not eligible for Medicare, and live in the service area of a participating provider. Those with incomes up to 57 percent of poverty are eligible for Medicaid,[15] but they are permitted to enroll in the BHP. The BHP offers a slimmer benefits package than Washington's Medicaid program—it will not pay for mental health treatments, prescription drugs, or vision care services.[16] In addition, the BHP excludes the first year of coverage for preexisting conditions.[17] All BHP members must obtain treatment through managed care providers, paid on a capitated basis. As of August 1991, the state had contracts with 15 providers in 14 of the state's 39 counties.

[13]In August 1991, the number of uninsured persons under the age of 65 in Washington was estimated to be 785,000; of this total, 450,000 had incomes within BHP's eligibility limit. Medicaid eligibility is not a disqualification from participation in the program.

[14]Enrollees whose family income temporarily exceeds this cap may continue in the program, but they must pay the entire premium, with no state subsidy, during that period. Members must leave BHP if their income stays above the eligibility level for 6 consecutive months.

[15]Eligibility level for AFDC family of three.

[16]Medicaid-eligible persons may wish to enroll in the BHP despite its smaller benefits package because they are guaranteed access to care through the BHP provider network, while it may be difficult for Medicaid beneficiaries to find physicians to provide their care.

[17]Before April 1, 1992, pregnancy was not treated as a preexisting condition. As of that date, pregnancy coverage was transferred to the state's First Steps program, which extends Medicaid to pregnant women within 185 percent of poverty. The apparent gap in coverage for women between 185 and 200 percent of poverty will not occur, because Medicaid counts unborn babies as family members in determining household income, making more families eligible.

The Washington BHP is funded both by state general revenues and individual premiums. Every member pays a monthly fee based on income; the minimum individual contribution is $7.50. In July 1991, the average family premium covered 15 percent of total program costs, and the average state contribution covered 85 percent. Between 1989 and 1991, the state budgeted $37.5 million for the BHP.

In Maine, the MHP began with state funds to expand Medicaid-like coverage to adults with incomes at or below 95 percent of the federal poverty level and to children under 20 with family incomes up to 125 percent of the poverty level.[18] The program now also receives HCFA cooperative agreement funds. The state Medicaid office administers the program and Medicaid providers serve program participants. Benefits are similar to the Medicaid package and, except for a small group of beneficiaries,[19] there is no participant cost sharing. Key features of the Washington and Maine programs are compared in table 3.2.

[18]The income ceiling for participants in Maine's Medicaid program is approximately 70 percent of the federal poverty level. Medicaid covers pregnant women and infants with family incomes up to 185 percent of the federal poverty level and children born after 9/30/83 with family incomes up to 133 percent of the poverty level.

[19]A transition program allows enrollees whose incomes rise above the program's income guidelines by up to 50 percent to remain in the program for 2 years if they pay a fee based on a sliding scale.

Table 3.2: A Comparison of Key Program Features: Washington Basic Health Plan and Maine Health Program

Program	Washington Basic Health Plan (BHP)	Maine Health Program
Enrollment	19,651[a]	9,000[b]
Estimated eligible	450,000[c]	37,000
Income eligibility	Up to 200 percent of poverty level	Up to 95 percent of poverty level for adults, 125 percent for children
Transition program	6 months, with no state subsidy for premium	2 years for children, 1 year for adults, with sliding-scale premium
Financing	State general fund and member premiums	State general revenues, HCFA funds, and premiums[d]
Benefits	Excludes dental, vision, and mental health care, as well as prescription drugs[e]	Similar to Medicaid
Provider	Capitated contracts with 15 managed care providers	Existing Medicaid providers on a Medicaid payment schedule

[a]As of August 1991.

[b]As of June 1991.

[c]Those below the age of 65 that meet BHP's income requirements.

[d]Premiums required in transition program for children in families with incomes between 100 and 125 percent of the poverty level.

[e]Washington's Medicaid program covers these benefits.

Coverage Extended to Limited Portion of Low-Income Population

Using different eligibility criteria, benefit packages, and provider arrangements, Washington and Maine have each successfully expanded health care coverage to a segment of their low-income populations. The numbers of people served by their programs, however, are constricted by budgetary limitations. Washington reaches only a small portion of those eligible for its program, and Maine has defined eligibility narrowly to encompass a small percentage of its uninsured.

In August 1991, Washington BHP enrollment stood at 19,651.[20] For fiscal years 1992 and 1993, the state legislature has authorized participation by 24,000 people. This number represents 5.3 percent of the 450,000 people

[20]BHP's enabling legislation set maximum program enrollment at 30,000. Subsequent budget constraints caused the governor to cap enrollment at 20,000 temporarily.

potentially eligible for the program and just over 3 percent of Washington's total uninsured population.[21]

The MHP is designed to cover the state's poorest uninsured residents. By limiting participation to those just beyond the Medicaid eligibility level, the program effectively targets the uninsured with the lowest incomes. In June 1991, the MHP served 8 percent of the state's total uninsured population: 9,000 persons, of whom 5,700 were adults. (Due to budget constraints, adult enrollment was closed at 5,700—currently no additional adults can join). With a peak enrollment of 11,400, the program has never covered much more than 10 percent of the state's approximately 113,000 uninsured.

Last year, Maine's program was awarded two HCFA demonstration cooperative agreements. Maine received approval for its program earmarked for children in October 1990. In October 1991, its demonstration for adults was approved, with implementation expected in 1992. With the HCFA money, MHP officials hope to expand coverage to more of the 37,000 people identified as eligible for the program but not yet participating.

Washington and Maine Use Different Methods to Control State Expenditures

The average cost of covering a BHP member in 1991 was about $1,100; state funds accounted for 85 percent of this amount.[22] The program incorporates a variety of features intended to control costs, including limits on covered benefits, an emphasis on preventive medicine, prospective capitated contracts with managed care providers, and member copayments to limit excess utilization. Costs have stayed within the predicted range, but program managers plan to review utilization rates to ensure that contracted reimbursement rates for managed care providers reflect actual utilization by BHP members.

MHP officials estimated that annually they spend an average $1,716 per adult and $660 per child to provide coverage. Due to budget constraints, the state legislature has made minor adjustments to the program's benefit and eligibility standards. To reduce costs, the state closed adult enrollment and sought to implement a primary care case management system.

[21]BHP administrators estimate that as many as 3,000 enrollees may be Medicaid-eligible. Since they would not be included in estimates of the state's uninsured, the actual percentage of uninsured participating in BHP may be slightly less than this estimate.

[22]The state has budgeted $1,260 per member beginning July 1, 1992, a program official indicated.

The HCFA demonstration funds will allow Maine to cover more individuals without additional state appropriations. In addition, because the same office administers Medicaid and the Maine Health Program, the state can ensure that applicants eligible for Medicaid are enrolled in that program, thus entitling the state to federal matching funds for applicants' coverage.

Goals and Financial Constraints Influenced Program Design

Washington officials designed the BHP to resemble insurance coverage. They wished to meet the needs of low-income residents without subjecting them to the perceived stigma of Medicaid participation. Two features of the plan, according to state officials and health policy analysts, reduce the stigma that can accompany public assistance. First, eligibility is determined solely on the basis of income; unlike Medicaid beneficiaries, BHP members do not have to prove indigence through an asset test. Second, program staff believe the mandatory premiums help preserve members' sense of dignity.

The need to secure widespread support to win legislative approval also influenced program design. To address concerns about financial risk, policymakers restricted the BHP to a pilot project covering only a limited number of people for a defined number of years. Aspects of the program intended to control costs also increased its appeal.

In contrast to Washington, Maine wanted to build on the state's Medicaid program because many uninsured people move in and out of Medicaid eligibility. In addition, state officials believed that the medical needs of the Medicaid population and those with incomes just above Medicaid eligibility would be comparable. The similarity between the programs allows the state to use the same staff to operate both, thus simplifying administration of the MHP.

Washington officials have recommended extension of the BHP beyond its scheduled 1992 expiration date. There is support for expanding the program to cover more people, but the state is facing a tighter budget than in past years, making substantial growth unlikely.

Because of this funding limitation, legislators and administrators are seeking ways to tie the plan more closely to Medicaid in order to become eligible for federal matching funds. HCFA recently awarded Washington a Medicaid demonstration grant. The grant will permit the state Medicaid program and the BHP to work in partnership with Spokane County to cover about 3,650 people with incomes between the Medicaid limit and 150

percent of poverty.[23] Continued cooperation between BHP and Medicaid may free state funds to bring additional members into the BHP.

MHP officials stated that their program is in a constant state of flux. With a tight budget, the legislature is looking at ways to reduce the cost of this program. The HCFA funds, however, will make it easier to continue the program. It will be evaluated before its scheduled 1993 expiration, which will help to determine its future.

[23]Because BHP's premium requirements and benefits differ from those of the state Medicaid program, the state may have to alter the program for these participants. For example, the benefits package may more closely match Medicaid's and some participants may be exempt from paying premiums.

States Reduce Barriers to Private Health Insurance

A number of states have used their own funds to provide health care coverage for the low-income uninsured, as discussed in chapter 3. In an attempt to expand coverage for other uninsured groups, without making significant demands on already strained budgets, states are attempting to ease access to the private health insurance market.

Two groups that have particular problems gaining access to health care coverage are people with high-cost health conditions and owners, as well as employees, of small businesses. Many states using an incremental approach to expanding access, as well as some states with more comprehensive initiatives, have taken measures to make it easier for these groups to obtain affordable health insurance in the private market. The techniques they are using include high-risk pools, insurance market reforms, and subsidies. (See table 4.1.)

Table 4.1: State Programs to Reduce Barriers to Private Health Insurance

State	High-risk pool	Small business reforms
Alabama		
Alaska		1966[a]
Arizona		1991
Arkansas		1991
California	1991	
Colorado	1991	1991
Connecticut	1976	1990
Delaware		1991
Florida	1983	1991
Georgia	1989[b]	1990
Hawaii		
Idaho		1981
Illinois	1989	1990
Indiana	1982	1985
Iowa	1987	1991
Kansas		1990
Kentucky		1990
Louisiana	1990[b]	1991
Maine	1988	1990
Maryland		1991
Massachusetts		
Michigan		1990
Minnesota	1976	1987
Mississippi	1991[b]	1982

(continued)

State	High-risk pool	Small business reforms
Missouri	1991	1990
Montana	1987	1991
Nebraska	1986	1991
Nevada		1987
New Hampshire		1982
New Jersey		
New Mexico	1988	1991
New York		1991
North Carolina		1991
North Dakota	1982	1991
Ohio		
Oklahoma		1988
Oregon	1990	1991
Pennsylvania		1979
Rhode Island		1990
South Carolina	1990	1991
South Dakota		1991
Tennessee	1987	1955
Texas	1989[b]	1982
Utah	1991	
Vermont		1991
Virginia		1990
Washington	1988	1986
West Virginia		1991
Wisconsin	1981	1991
Wyoming	1991	1990

Note: Only programs passed as of November 1991 are included.

[a]Year indicates when most recent reform became operational.

[b]Legislation passed, but risk pool not operational.

High-Risk Pools Expand Access to Health Insurance

Of the more than 33 million people in the United States without health insurance, an estimated 1 to 2 million are considered in need of, or at risk of needing, extensive health care services. Some states have established high-risk pools to provide health insurance for these people and to spread the financial risk of their health care costs among all health insurers in the state.

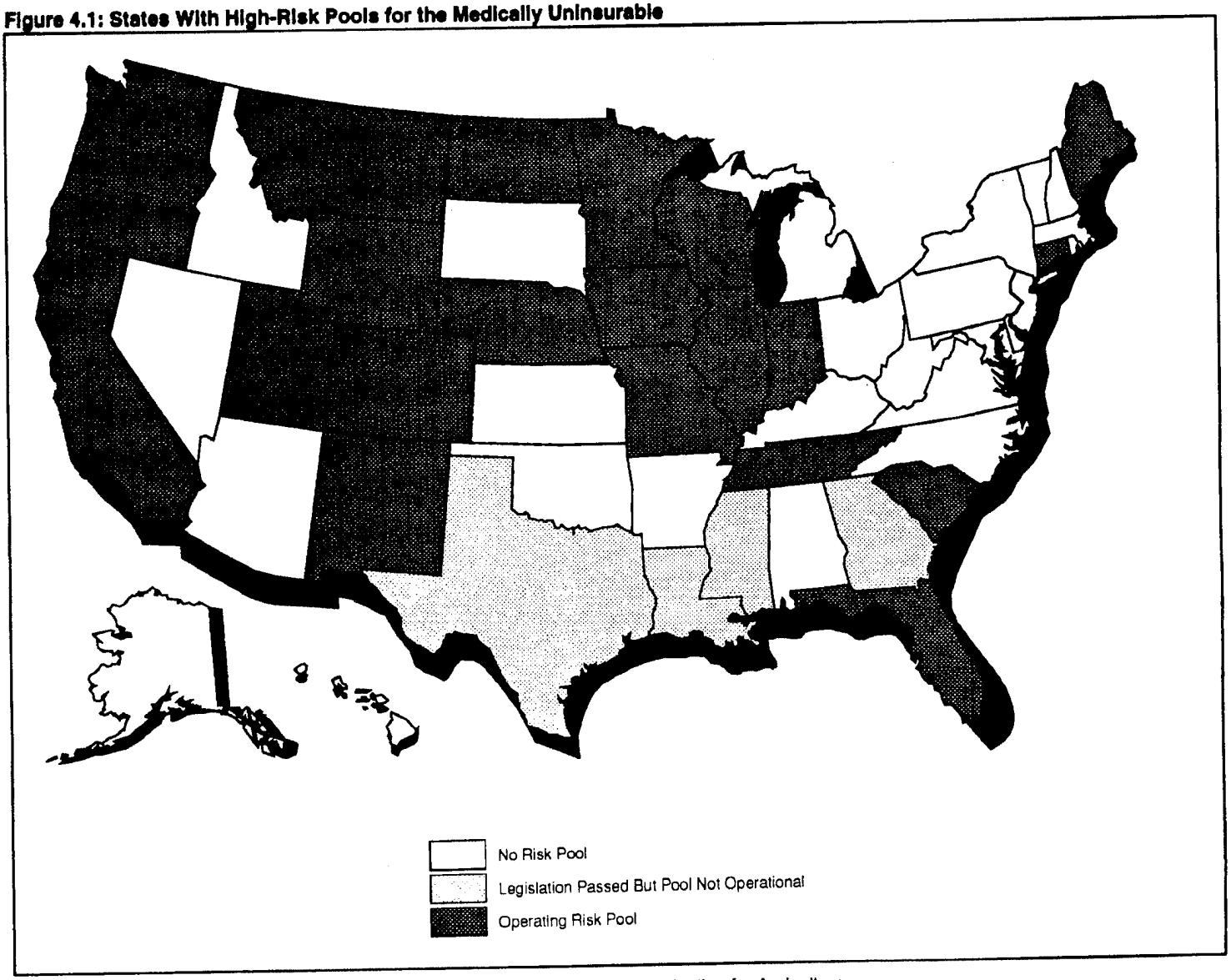
As of late 1991, 25 states had legislated or were operating high-risk pools to insure "medically uninsurable" people in their states (see fig. 4.1).[1] On average, beneficiaries pay approximately 60 percent of a pool's total claims.[2] The remaining 40 percent is covered, in most cases, by insurance company assessments.[3]

[1]Of the 25 states with pools, 21 are now operating.

[2]This proportion ranges from 40 to 100 percent in individual states.

[3]California, Illinois, Maine, and Tennessee make up the difference between premiums and claims through allocations from general revenues; Colorado uses a special state income tax surcharge.

Figure 4.1: States With High-Risk Pools for the Medically Uninsurable



Source: Compiled by Communicating for Agriculture.

High-risk pools have been successful in providing coverage to nearly 77,000 persons. The pools, however, have problems. First, the cost to beneficiaries may be more than beneficiaries are willing or able to pay. Premiums paid by beneficiaries generally equal between 125 and 400 percent of the average individual health insurance premium available in the state. Second, the ERISA preemption provision limits the pool's funding

base because states cannot regulate self-insured companies and require them to participate in health insurance assessments to finance the pools. Finally, the ability of insurance providers (both self-insured employers and insurance companies) to exclude high-risk people from their insured groups, in order to offer a lower premium, leads to a shift of high-cost individuals from the private insurance market to the state-controlled pools. This can result in higher premiums for those who must rely on high-risk pools for coverage.

Minnesota High-Risk Pool Expands Access to 30,000 People

Minnesota's experience exemplifies some of the successes and dilemmas of using a high-risk pool to address the problem of insuring those with high-cost health care. The state operates the nation's largest, and one of the longest-running, high-risk insurance pools;[4] its goal in developing the pool was to group people with medical problems and provide them access to health insurance at a generally affordable rate. The program is intended to insure only high-cost people who are deemed uninsurable. In January 1992, the Minnesota Comprehensive Health Association (MCHA) covered over 30,000 persons, almost double the number insured in January 1989.

Those who are denied coverage by private insurers because of their health status can purchase individual coverage from MCHA. In 1991, the average individual premium for MCHA coverage was $105 a month. This premium is equal to 125 percent of the average rate charged by the five largest-selling private group health insurance plans with benefits similar to those of MCHA. The risk-pool premium has always been lower than the highest of the five premiums used to determine the pool's rates. Any difference between premiums collected and claims paid by the pool is funded by levying surcharges, based on each insurance company's market share, on all the state's private health insurers.

The high-risk pool is intended to be the insurer of last resort. People may, therefore, apply for coverage only after being denied coverage, offered coverage at a higher than standard premium, or offered coverage with substantial coverage limitations. Eligibility has expanded since the program's 1976 inception to include (1) Medicare patients who do not qualify for Medicare Part B, (2) those who lose their jobs and cannot purchase COBRA coverage to continue their health insurance because their former employers canceled insurance or went out of business, and (3) employees of firms that discontinue health benefits or go out of business.

[4]Minnesota and Connecticut both have operated their high-risk pools since 1976.

In May 1991, the Minnesota legislature passed a law expanding pool eligibility. The new law states that Minnesota residents may enroll in the pool with no preexisting condition exclusion if they apply 90 days before termination of previous coverage and if previous coverage is not terminated due to fraud or nonpayment of premiums. Under the new law, termination of previous coverage includes exceeding the maximum lifetime benefit of existing coverage.

The risk-pool plan covers a full range of medical services for medically necessary diagnosis or treatment of illness. Benefits include hospital room and board, physician services, private duty nurses, and prescription drugs. There is a 6-month preexisting condition exclusion if the condition was treated during the 90 days before the purchase of high-risk pool coverage. Because the pool is administered by Blue Cross, provider payments are based on the Blue Cross fee schedule. As a result, providers have the same incentive to serve high-risk pool beneficiaries as they do patients covered by Blue Cross.

Minnesota's High-Risk Pool Attempts to Control Costs Through Management of Care

In order to save additional costs, beneficiaries are given incentives to obtain covered services through a preferred provider organization (PPO).[5] This controls pool costs because the plan reimburses providers on the basis of a fee schedule and negotiated hospital rates. The PPO also allows for greater management of care, which MCHA officials hope eliminates unnecessary and inefficient provision of services.

MCHA officials estimate that since they began managing care for their beneficiaries, their policies have reduced the pool's total costs by nearly 15 percent, or over $5 million. The PPO network, however, is not a totally closed system. Beneficiaries can choose providers outside the PPO, but they will pay more for that care than if beneficiaries received it through the PPO.

Rising Costs May Hamper Pool Effectiveness

Minnesota's program has had some success in achieving its goals. The pool, however, may be limited in its ability to assist some of the high-risk people for whom it was intended. At $105 a month, premiums that are generally affordable may be prohibitive for low-income people. Most

[5]A PPO contracts with a group of providers to provide health care services under defined financial arrangements.

people insured through the high-risk pool must pay the premium themselves, with no assistance from their employers.[6]

Wisconsin, which also operates a high-risk pool, has attempted to address the problem of unaffordable premiums by subsidizing up to one-third of premiums and waiving deductibles for low-income beneficiaries. Currently, 40 percent of Wisconsin's high-risk pool beneficiaries receive some state subsidy. Even with the subsidy, however, the monthly premium for a 60-year-old man can run as high as $275.

Minnesota's high-risk pool may also encounter a funding problem because small businesses are beginning to exclude people with expensive medical conditions from their insurance plans in order to get lower rates for their other employees.[7] The excluded employees must then obtain coverage from the high-risk pool. Concentrating more people with expensive medical conditions in the high-risk pool may cause pool expenses to rise, potentially necessitating changes in pool financing. The incentive to exclude high-cost beneficiaries could increase as health care costs continue to grow.

State Officials Seek Freedom From Federal Limitations

Minnesota created its high-risk pool because it provides high-risk people access to health insurance without allocating state funds from general revenues. Insurance industry assessments, which currently account for nearly 1 percent of health insurance premiums collected by insurers, and operation by Blue Cross have permitted the state to expand access to this group with minimal direct involvement—the legislature does not need to allocate funds every year in order to maintain the pool.

In order to continue operating the pool smoothly and to keep insurance assessments as low as possible, MCHA staff would like to expand the funding base for the risk pool. Because of the ERISA preemption clause, states can only regulate insurance companies, but not employee health plans, such as those provided by employers who self-insure. Thus, the burden of assessments to cover losses of the high-risk pools falls on private insurers, which nationwide constitute only 60 to 65 percent of the health insurance market. Moreover, as the number of firms opting to self-insure grows, the funding base for high-risk pools will shrink.

[6]Employers pay premiums for approximately 3,000 MCHA-covered individuals.

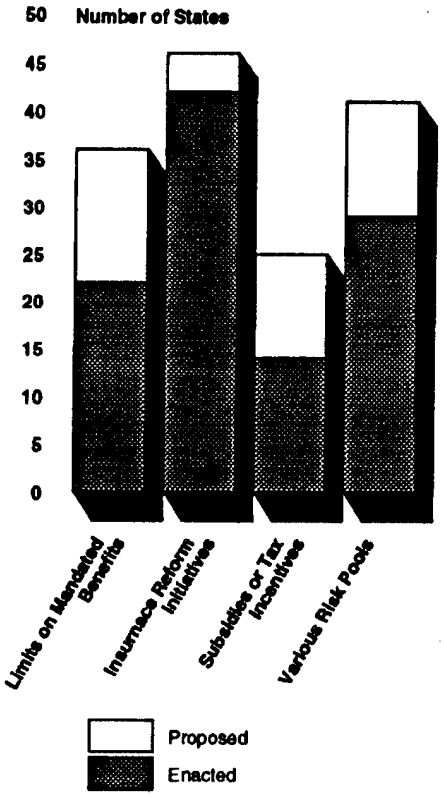
[7]Carving out individuals from an insured group is generally illegal in Minnesota if employers do not comply with certain laws, but loopholes exist that allow this to happen.

Most States Attempt to Help Small Business Employees Gain Access to Health Insurance

Although U.S. health insurance is primarily employment-based, about three-fourths of Americans who lack health insurance are workers or their dependents. Just over half of uninsured workers are employed by firms with fewer than 25 employees; these firms are commonly defined as small businesses. Employees of these small businesses are uninsured for various reasons, but barriers to affordability and accessibility are major causes of lack of coverage. Because of their disadvantaged position in a highly competitive health insurance market, small businesses are more likely than larger firms to face higher premium costs, as well as denial or cancellation of coverage. Another factor contributing to lack of coverage for small business employees is the disinclination of some employers to offer insurance.

Nearly all states have recently adopted or proposed measures aimed at improving access to affordable health insurance for small firms and their employees. The number of states that have enacted or proposed various strategies to make health insurance more affordable and available for small business employees is shown in figure 4.2.

Figure 4.2: Number of States With Enacted or Proposed Small Business Reforms



State approaches to expanding access for small firms include (1) regulatory reforms to improve the general availability and affordability of health insurance for small groups, (2) waiving state-mandated health benefits for small employers in an effort to lower premiums, (3) providing direct subsidies and tax credits to employers and employees, and (4) facilitating pooling of small groups to spread their risks and enhance their negotiating power. Many of the state initiatives were adopted within the past 2 years, but early indications are that they have had only modest impact on the number of firms offering health insurance. The initiatives have been successful in addressing some of the disadvantages small firms and their employees face in the health insurance market, but their effect on increasing the number of small business employees with health insurance coverage is more uncertain. Our companion report, Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90,

May 1992), provides a more detailed discussion of state efforts to modify the health insurance market for small businesses.

Insurance Market Practices Adversely Affect Small Employers

Small firms purchase insurance in a market where many insurers aggressively underwrite (review characteristics of individuals and groups and how those characteristics affect the risk of insuring) to select and retain potentially profitable, low-risk clients. Premiums for such groups reflect high insurance marketing and administrative costs, as well as higher costs due to the lack of time or skilled personnel to seek and negotiate suitable, affordable coverage.

Regulatory Reforms May Improve Availability of Insurance, but Raise Average Premiums

States have been particularly active in the past 2 years in limiting the extent to which insurance companies can deny coverage or price high-risk firms or individuals out of the insurance market. Forty-three states have adopted one or more insurance regulatory reforms that affect the small-group market. Reforms include measures to help ensure that (1) employees who want health insurance will be accepted and renewed by insurers; (2) waiting periods for coverage of preexisting conditions will be short, will occur only once, and will be based only on recent medical history; (3) coverage will be continuous; and (4) extremes in premium costs will be narrowed to fall within ranges specified by the states.

These reforms are aimed at correcting a growing sense of unfairness in the insurance market. The reforms give firms and employees greater assurance that they will be able to obtain or retain insurance coverage, even if individuals change jobs or experience costly medical conditions. However, while these reforms may make it easier for some individuals to obtain coverage, they are expected to raise the average level of premiums for others. Time for these state initiatives to develop fully and more information about their effects will be needed before a conclusive assessment can be made of whether the net outcome is an increase or decrease in the number of small business employees with health insurance coverage.

Waiving Mandated Benefits Has Produced Modest Response

States have given insurance companies greater flexibility in designing less costly insurance packages for small businesses. Nearly half of the states have passed legislation reducing or eliminating health insurance coverage requirements—"mandated benefits"—and now permit insurance companies to offer lower cost "bare bones" health insurance policies to

small firms. In response, insurers in most of those states have offered plans to the small-group market with premiums up to 40 percent lower than existing small-group policies. In addition to excluding previously mandated benefits, these plans often incorporate higher cost sharing and preexisting-condition clauses.

Response to these emerging plans has thus far been modest, partly because eliminating mandated benefits does not yield large enough premium reductions and partly because the other policy limitations do not make these policies attractive enough for the firm and its employees. This early experience with mandated benefits suggests that it is not the cost of the mandated benefits that prevents small businesses from providing health benefits, but more likely the high and rising cost of all health care services.

Subsidies Have Had Limited Success, Are Constrained by State Budgets

Several states have also addressed the cost issue facing small firms in the insurance market by subsidizing insurance premiums. Twenty-one states have tried to use direct and indirect subsidies, including tax credits and premium tax waivers, to make health insurance easier for employers to provide and for employees to purchase.

Few states responded to the inducement of even substantial premium subsidies. A New York pilot program offering a 50 percent premium subsidy resulted in a 3.5 percent increase in the number of small firms offering health insurance; analysts estimate that if the program was better targeted to the small business market, it would increase the number of firms providing coverage by 16.5 percent. The Robert Wood Johnson Foundation's Health Care for the Uninsured Program—which piloted experiments including subsidies, small-employer pooling, and lower cost health plans—reported that even the most successful of its operating programs had enrolled less than 17 percent of the small business market.

Subsidies are costly, causing some states to restrict the scope of subsidy programs in light of their current budget problems. Most states have limited subsidies to firms that had not offered health insurance during the previous 2 or 3 years. Small firms already offering such coverage felt that this placed them at a competitive disadvantage. Because of budget constraints, some states have abandoned or limited the scope of programs that require state funds.

Pooling of Risks Moderates Some Small-Firm Disadvantages

Finally, some states have tried to address the disadvantages small firms face in the marketplace precisely because they are small—an inability to spread risks across a large number of employees and an inability to exert any power in the market for health services. States, in cooperation with insurance carriers, have set up mechanisms for redistributing the high health risks of certain employees across a greater number, or pool, of employees. These mechanisms include (1) high-risk pools for individuals who are denied health insurance or can obtain it only at prohibitive cost because of expensive medical conditions, (2) reinsurance pools to help insurers mitigate expected high losses caused by insuring high-risk enrollees, and (3) small-employer pools, in which small businesses band together to purchase health insurance.

High-risk pools are discussed earlier in this chapter. The pools enable individuals who can afford the expensive pool premiums to obtain coverage, while at the same time enabling their healthier coworkers to obtain less costly group coverage. Some states, however, prohibit this enrollee selection practice known as "carving out;" they want to avoid (1) shifting of costs from employers to the high-risk individuals and (2) the pass-through costs small groups can incur when insurers are assessed to cover part of pool costs.

Reinsurance pools help insurers accept entire small-employer groups regardless of the health status of individual members. Experience with reinsurance pools has been limited because they were adopted in Connecticut, North Carolina, and Oregon within the past 2 years.

Privately sponsored and state-facilitated small-employer pools have improved affordability and access for some small firms. Their success has been somewhat tarnished, however, by a number of private small-employer pools that have gone out of business or failed to pay claims, leaving groups and individuals with millions of dollars of unpaid bills. An additional problem has been a concentration of high-risk small-employer groups in pools, while low-risk groups obtain less costly insurance elsewhere.

Payment Reform Can Reduce Health Care Costs

Some states are trying to address the problem of rising health care costs by reforming the methods of reimbursing health care providers. State officials believe they can reduce health costs by setting hospital rates or decreasing the health care system's administrative complexity. Maryland has had the longest continuous experience with hospital rate regulation, and its system is credited with stemming cost growth and improving access to care for certain groups. New York recently began operating a single-payer project that will handle all the billing and payment procedures for 25 of the state's hospitals in order to reduce administrative costs.

Maryland has set hospital rates through rate regulation since 1971, and now operates the country's only all-payer hospital payment system. Maryland's all-payer system provides for nearly uniform payments by all insurers and creates incentives for hospitals to keep cost growth below the national average. State officials believe this rate-setting system has reduced hospital cost growth measurably and has resulted in greater equity between public and private insurers.

New York is now beginning to establish a single payer for hospitals. Hospitals participating in this demonstration project submit all claims to the single payer, which will handle and coordinate all claims processing. State officials developed the single payer to achieve significant administrative cost savings.

An important factor contributing to the implementation of these two reforms has been the support they have received from participants in the states' health care systems. In both Maryland and New York, government and provider groups participated in the program development; in Maryland, their continued involvement facilitates ongoing operation of the program.

Maryland's Hospital Rate Setting Reduces Growth in Hospital Costs

Beginning in 1971, Maryland implemented a series of hospital rate-setting regulations to control growth in hospital costs. The rate-setting system now operates as an all-payer system that determines each hospital's rates by the types and volume of services it provides to patients. An all-payer system also requires that all payers—both public and private—pay nearly identical rates for the services for which they are liable.[1] The rate-setting process is controlled and operated by the Maryland Health Services Cost Review Commission.

[1]Medicare and Medicaid receive a 6 percent discount as part of the HCFA waiver. Blue Cross and some health maintenance organizations receive a 6 percent discount because they offer open-enrollment plans and they provide cash advances to hospitals.

The rate-setting system has succeeded in achieving the commission's goal of creating greater equity among groups of hospital patients. Because of the all-payer system, it is difficult for hospitals to shift costs among payers; a hospital receives the same rate for serving a Medicaid patient or a privately insured individual.

Along with creating equitable payments, the rate-setting process has controlled costs more effectively than rate-regulation programs in other states. Since 1977, Maryland's per admission hospital costs have grown more slowly than elsewhere and had, by 1991, fallen from 25 percent above the national average to 10 percent below. Supporting these data, a recent GAO study, explaining factors contributing to interstate variations in health care spending, cites all-payer systems as reducing hospital costs between 2 and 13 percent.[2]

In order for Maryland to achieve the goal of equitable pricing for all payer groups, it first needed a Medicare waiver from HCFA. Maryland had to assure HCFA that the all-payer system would cost the federal government no more than Medicare and Medicaid would have cost without the waiver. The state's desire to retain the waiver provides an incentive to keep growth in hospital costs below the national average. Since the waiver was granted in 1977, HCFA payments for Medicare and Medicaid have risen more slowly in Maryland than they have nationwide.

Maryland's rate-setting process was more effective than all-payer systems tried by other states. Massachusetts, New Jersey, and New York also received HCFA waivers to implement all-payer systems, but the states allowed the waivers to expire. The states were unable to keep cost growth low enough to ensure that their Medicare and Medicaid programs cost the federal government less than they would have without rate setting.

The current rate-setting system was implemented in three stages. The first, implemented between 1972 and 1977, used a rate review methodology that followed a standard budget review process—a simple examination of a hospital's direct costs, revenues, and output measures. This process established rates, or a hospital's actual payments, for all procedures performed in each hospital based on the "reasonableness" of the hospital's costs.

[2]Health Care Spending: Nonpolicy Factors Account for Most Interstate Differences (GAO/HRD-92-36, Feb. 1992).

The second stage added a rate-adjustment process to the budget review. This process is used to adjust rates for changes in inflation and patient volume, and it includes mechanisms that provide financial incentives for hospitals to control costs.

The final phase developed cost-containment strategies by limiting both revenue per patient and total hospital revenue. A number of additional modifications have been considered over the years, but most were never implemented because they were so complex and it was difficult to gain consensus on how to put them into practice. Others, however, have been implemented. For example, the commission has tied the rate of hospital revenue growth to the average national cost growth rate per admission.

Rate Regulation Reduces Hospital Cost Growth

Maryland's rate-setting system reduces hospital costs by providing hospitals an incentive to find less expensive ways to operate. For each case, the system compares a hospital's charges, based on their approved rates, with a case-mix adjusted standard, generally using New York State's diagnosis-related groups. If the total charges of the hospital are lower than the standard, then the hospital's unit rates will rise; if not, the unit rates will fall. Thus, the standard creates an incentive for hospitals to find ways to lower their costs in order to increase their rates. The new rates, however, will still be lower than the established standards. Rates are adjusted each year for inflation.

The state commission and the state's hospital officials believe that rate regulation in Maryland has worked. In 1976, per-admission costs in Maryland were 25 percent above the national average; by 1991, they had fallen to 10 percent below average. In 1991, Maryland's per-admission costs rose at a rate of 6.88 percent, a rate lower than the national average increase of 9.77 percent. The commission estimates that in 1991, Maryland's regulations saved residents $92.4 million in hospital costs over what they would have spent without the regulations.

This extended period of regulation appears also not to have excessively limited hospital profit margins. Between 1976 and 1991, Maryland hospitals, as a group, have generally earned 1 to 3 percent of total revenue as profit, comparable to 1988 profit margins for hospitals nationwide, which ranged from 1.8 percent to 5.3 percent, depending on the type of hospital.[3] During no year did the hospitals as a group lose money. In

[3]According to the Prospective Payment Assessment Commission, nationwide, large urban hospitals treating a large number of uninsured patients had the smallest margins, averaging 1.8 percent; large rural hospitals had the highest margins, averaging 5.3 percent.

addition, an official with the Maryland Hospital Association said, this period of close regulation was more profitable for hospitals than the period before regulation. The official believes that the current regulatory system is an improvement because hospitals are now able to participate extensively in payment negotiations that determine their rates.

Equal Payments and Payments for Uncompensated Care Improve Access

The Maryland rate-setting system improves access to hospital care in two ways. First, it pays hospitals for uncompensated care directly in their rates. Second, equal payments across insured groups result in equal access for all insured patients—including Medicaid patients.

Payments for a hospital's uncompensated care are made using a standard-of-reasonableness criterion. Hospital rates are adjusted by a predetermined percentage, based on each hospital's uncompensated care volume. Thus, a hospital providing proportionally more uncompensated care will have higher rates than a hospital providing less.

Hospitals also do not benefit financially by serving certain select insured groups. Because payment rates are uniform, hospitals receive the same payment for serving a privately insured person or a Medicaid beneficiary. Thus, equal payments encourage hospitals to serve all patients.

Hospital Support and Cooperation Vital to the Current System

Maryland's hospital rate-setting process was developed largely as the result of lobbying by the state's hospital association. The association advocated this system because the previous cost-based payment system did not allow hospitals to participate in the rate-setting process or to collect for the increasing level of uncompensated care they were providing. In addition, cooperation from the hospital association made it easier for the legislature to pass the rate-setting reforms.

New York's Single-Payer Demonstration Project Will Attempt to Reduce Administrative Costs

In 1991, New York State's department of health instituted the Single Payer Demonstration Project, which is now establishing a single payer for hospitals.[4] The goal of the demonstration project is to reduce health care system overhead costs by coordinating billing and payment procedures for 25 hospitals in New York State.

The single payer is now the central point for submitting and paying health insurance claims for hospitals choosing to participate in the

[4]The project was established with a $600,000 grant provided by the Robert Wood Johnson Foundation.

demonstration. Providers submit claims to the clearinghouse, which compiles, edits, and submits blocks of claims to insurers. Insurers include insurance companies, Medicare and Medicaid, and other organizations that insure individual patients. Participating hospitals are located in northeastern New York, the Hudson Valley, Long Island, and New York City.

All participating hospitals transmit billing data electronically to the clearinghouse, which edits and formats it according to payer specifications. The clearinghouse then batches and forwards all claims to the responsible insurer.

Program officials hope, eventually, to initiate point-of-service eligibility verification systems that would establish insurance and benefit coverage information about each patient, as well as provide immediate beneficiary copayment and deductible information to service providers. In addition, the clearinghouse will explore implementing an automatic coordination-of-benefits process between insurers for individuals covered by more than one plan. Standardization of billing procedures will facilitate these procedures.

Project officials have contracted with two computer vendors to operate this system. These two companies are building the claims clearinghouse and providing computer services and support to hospitals. As of January 1992, one hospital was submitting claims through the single-payer project and additional hospitals were expected to begin submitting claims during the next year.

System May Reduce Administrative Costs, but Does Not Address Access Problems

The Single Payer Demonstration Program was developed by the department of health as part of a proposal to achieve universal access to health care coverage. State health officials believe that coordinating billing procedures, using electronic systems, and establishing patient eligibility and payment information will reduce health care system administrative costs. The amount saved by the program cannot be determined as yet, but it is expected to be several times its operational cost. The Single-Payer Demonstration Program, however, does not directly address the problem of limited access to care.

Support by Interested Parties Key to Single-Payer Demonstration

The single payer was designed to work with any of the major reform proposals that are currently being considered in New York State—including mandating employer-provided insurance and single-payer

plans. Health department officials view the clearinghouse as a component of any broader reform plan that might be adopted, as well as a natural development that takes advantage of current technology.

A key factor in the implementation of the single-payer program was support from most interested parties in the state. Insurers, providers, and state residents believe the single-payer program will reduce administrative costs and therefore they support its implementation. Hospitals are demonstrating their support through their willingness to participate.

State Officials Hope Single-Payer Program Will Expand

Health department officials hope that all hospitals, clinics, and physicians in New York State will eventually choose to participate in the program in order to benefit from the savings that result from reduced administrative costs. The use of state-of-the-art technology alone should provide significant savings to both hospitals and insurance companies. In addition, insurance companies will have a smaller role in processing claims. Coordinated electronic billing will make each claim less expensive to process.

The health department sees the Single-Payer Demonstration Program as the first step in a process toward a centralized single-payer system for all providers in the state. A goal of the demonstration project is to determine the best design for the single-payer system, how much money the system will save, what technologies will be necessary to operate the system, and any approaches the state should take to ensure the establishment of a single-payer system.

Health department officials think that the single-payer program is a necessary step to address problems in the health care system—whether or not fundamental reform occurs. They believe waste must be eliminated from the health care system and the single payer is one way to alleviate this problem.

Conclusions and Matters for Congressional Consideration

Conclusions

States are trying to expand access to health insurance while controlling increases in health care costs. Their approaches range from narrowly focused efforts to reform the health insurance market or contain hospital costs to comprehensive initiatives to achieve universal access to health care coverage. Activity on the state level is constant; in early 1992, three additional states—Florida, Minnesota, and Vermont—enacted comprehensive health care packages.

States using their own funds to expand access to coverage for specific groups in the uninsured population usually are constrained by budgetary problems. At a time when it is difficult for states simply to maintain existing programs, efforts to assist the uninsured must operate within severe budgetary strictures. As a result of these limitations, state access programs reach only a small percentage of the uninsured population.

Comprehensive solutions have proved challenging to formulate and implement. States face a series of hurdles to providing access to coverage for all their residents. Reaching a consensus on how to achieve universal access can be very difficult, as various initiatives have differing impacts on the different parties affected by systemic reforms. As state governments consider proposals for change, these disparate interests are concerned about the extent to which they will be asked to shoulder the burden for the cost containment strategies that are often a means of funding expanded access.

In addition to these political and budgetary problems, states have to contend with restrictions in federal laws and regulations. A state has little chance of implementing a comprehensive reform plan without federal cooperation. ERISA hinders states seeking comprehensive solutions to health care access and cost problems by restricting the choices available to them. Additionally, a state may require waivers from federal Medicaid regulations or other federal actions to implement its plan.

When state officials design plans involving employer-provided insurance, one factor they take into account is the need to create a plan compatible with the restrictions of ERISA. A state that wishes to rely on employer-provided insurance may try to obtain a statutory exemption from the ERISA preemption clause in order to regulate health benefit plans offered by self-insured employers, thus exercising control over all employer-provided insurance in the state. Until now, only Hawaii has received such an exemption. Absent such legislation, some states have tried to circumvent ERISA by relying on other state prerogatives, such as

the power to tax. States that have chosen this second route have not yet implemented their plans; therefore, no court has yet ruled on whether these plans are, in fact, not subject to the requirements of ERISA.

Matters for Congressional Consideration

States are hampered by the ERISA preemption provision, which makes it difficult to design and implement innovative health care reforms. If the Congress wants to give states more flexibility to develop comprehensive reforms, it should consider whether to amend ERISA so that the Department of Labor can give states a limited waiver from ERISA's preemption clause in order to develop innovative approaches to employer-based health insurance. The Congress could define minimum standards—governing such factors as benefits packages, extent of coverage, and terms under which the waiver might be revoked—that a state must meet to receive and maintain such a waiver.

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